New Jersey

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United Healthcare Community Plan

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Welcome

Welcome to UnitedHealthcare Community Plan

Please take a few minutes to review this Member Handbook. We're ready to answer any questions you may have. You can find answers to most questions at **myuhc.com/CommunityPlan**. Or, you can call Member Services at **1-800-941-4647**, TTY **711**, 24 hours a day, 7 days a week.

UnitedHealthcare Community Plan

Getting started

We want you to get the most from your health plan right away. Start with these three easy steps:

1. Call your Primary Care Provider (PCP) and schedule a checkup

Regular checkups are important for good health. Your PCP's phone number should be listed on the member ID card that you recently received in the mail. If you don't know your PCP's number, or if you'd like help scheduling a checkup, call Member Services at **1-800-941-4647**, TTY **711**. We're here to help.

2. Take your Health Assessment

This is a short and easy way to get a big picture of your current lifestyle and health. This helps us match you with the benefits and services available to you. Go to **myuhc.com/CommunityPlan** to complete the Health Assessment today. Also, we will call you soon to welcome you to the UnitedHealthcare Community Plan (UnitedHealthcare). During this call, we can explain your health plan benefits. We can also help you complete the Health Assessment over the phone. See page 12.

3. Get to know your health plan

Start with the Health Plan Highlights section on page 10 for a quick overview of your new plan. And be sure to keep this booklet handy, for future reference.

Thank you for choosing UnitedHealthcare Community Plan for your health plan

Dear new member:

Welcome to UnitedHealthcare Community Plan!

Whether you just joined us as a new member of NJ FamilyCare or transferred to UnitedHealthcare Community Plan from another health plan that participates in the NJ FamilyCare program, we are very pleased that you have chosen UnitedHealthcare Community Plan. We will work with you and your doctor to make sure that you get all of the health care services that you need. **If your doctor is not a UnitedHealthcare Community Plan doctor, call UnitedHealthcare Community Plan's Member Services toll-free at 1-800-941-4647, TTY 711, for help in choosing a UnitedHealthcare Community Plan provider.** You can rely on the UnitedHealthcare Community Plan staff and UnitedHealthcare Community Plan providers to treat you with dignity and respect.

UnitedHealthcare Community Plan is always available to help you. You can call Member Services 24 hours a day, 7 days a week toll-free at **1-800-941-4647** or TTY **711**. A UnitedHealthcare Community Plan representative will always be there to help you.

The UnitedHealthcare Community Plan Member Handbook tells you about all of the health care services you can get as a member of UnitedHealthcare Community Plan and how to get them. It also tells you what to do whenever you have an emergency or other type of problem.

UnitedHealthcare Community Plan is concerned about your health and recommends that you receive all of the preventive health care examinations for your age. If you have changed Primary Care Providers, we want you to visit your new Primary Care Provider to get an examination. Please tell your former Primary Care Provider to transfer your medical records to your new Primary Care Provider. NJ FamilyCare members are not charged for this service.

Your UnitedHealthcare Community Plan membership ID card will be sent to you soon. If you have not received your ID card and you need to get health care services, take this letter with you when you get any health care services until your ID card arrives. Your Primary Care Provider or any other provider can call UnitedHealthcare Community Plan at **1-800-941-4647** to make sure that you are a UnitedHealthcare Community Plan member. If you need a Provider Directory that lists all of UnitedHealthcare Community Plan's providers, call Member Services toll-free at **1-800-941-4647**, TTY **711**.

We are glad to have you as a member of UnitedHealthcare Community Plan. Remember, we're always here to help you. If you need to contact us, our toll-free number is **1-800-941-4647**, TTY **711**. Please also contact us at that number to let us know what telephone number we can use to get in touch with you quickly.

If you have any questions about how to use your UnitedHealthcare Community Plan benefits, if you want to change your Primary Care Provider, if you have questions about your Primary Care Provider, or want to learn more about any of our services, call Member Services at **1-800-941-4647** or TTY **711**, 24 hours a day, 7 days a week. For better health care, UnitedHealthcare Community Plan is here for you.

Sincerely,

Charles Wayland, CEO
UnitedHealthcare Community Plan

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Enrollment in UnitedHealthcare Community Plan

UnitedHealthcare Community Plan (UnitedHealthcare) is a health plan that gives you and your family a full range of health care services. With UnitedHealthcare, you choose a personal doctor for each member of your family who has been enrolled in UnitedHealthcare.

UnitedHealthcare will work with you and your UnitedHealthcare doctor to make sure that you get all the services you need to stay healthy. There are no limits on the number of times you may see your UnitedHealthcare doctor for health care. UnitedHealthcare has doctors in all of New Jersey's 21 counties.

UnitedHealthcare Community Plan is always available to help you. You can call Member Services 24 hours a day, 7 days a week toll-free at **1-800-941-4647** or TTY **711**, for emergency situations. For non-medical questions, please call back during normal business hours from 8:00 a.m. to 6:00 p.m. EST, Monday through Friday. A UnitedHealthcare Community Plan representative will always be there to help you.

You can be a member of UnitedHealthcare if you live in New Jersey and receive NJ FamilyCare. Your benefits are decided by the State of New Jersey. The different NJ FamilyCare benefit packages will be explained later in this handbook. The Division of Medical Assistance and Health Services (DMAHS) must verify and approve your enrollment in UnitedHealthcare. It may take between 30 and 45 days after you apply to join UnitedHealthcare for your membership to become effective. Coverage with UnitedHealthcare will become effective on the first day of the month after you are approved. If you were covered by the NJ FamilyCare fee-for-service (FFS) program or another health plan during this waiting period, you will continue to receive health care benefits from FFS or your previous health plan until your enrollment in UnitedHealthcare becomes effective.

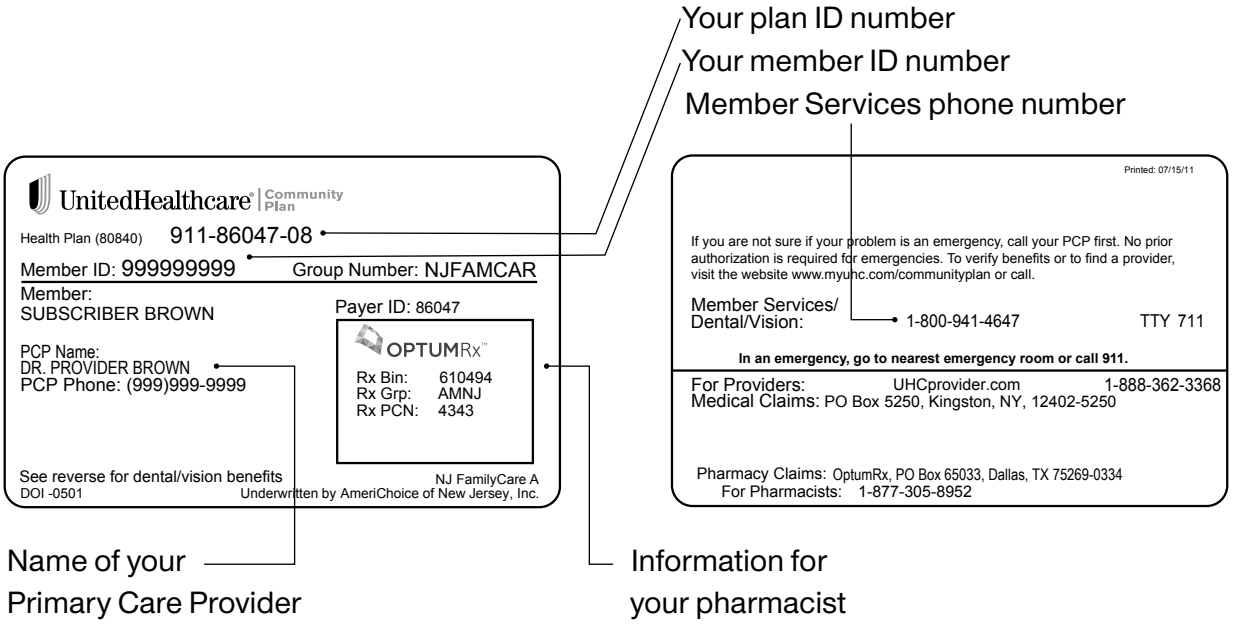
By signing the Enrollment Application, the enrollee or person authorized to sign for the enrollee allows for the release of the enrollee's medical records to UnitedHealthcare. The health information included on your application will be sent to UnitedHealthcare by the Health Benefits Coordinator (HBC).

If you are getting medical services before your enrollment with UnitedHealthcare, you should call and tell us:

- A listing of the services that you are receiving
- The names of the doctors that you are seeing
- The locations where you are seeing them

Health plan highlights

Member ID card



Your member ID card holds a lot of important information. It gives you access to your covered benefits. You should have received your member ID card in the mail within 7 days of joining UnitedHealthcare Community Plan. Each family member will have their own card. Check to make sure that all the information is correct. You must use your member ID Card to get all covered non-emergency care from UnitedHealthcare providers. If any information is wrong, call Member Services at **1-800-941-4647**, TTY **711**.

- Take your member ID card to your appointments
- Show it when you fill a prescription
- Have it ready when you call Member Services; this helps us serve you better
- Do not let someone else use your card(s). It is against the law

Show both cards. Always show your UnitedHealthcare ID card **and** your Health Benefits ID (HBID) card when you get care. The HBID is the ID card you received when you joined NJ FamilyCare. This helps ensure that you get all the benefits available. It also prevents billing mistakes. You will need to bring identification with you to your provider appointment.

Benefits at a glance

As a UnitedHealthcare member, you have a variety of health care benefits and services available to you. Here is a brief overview. You'll find a complete listing in the Benefits section.

Primary care services

You are covered for all visits to your Primary Care Provider (PCP). Your PCP is the main doctor you will see for most of your health care. This includes checkups, treatment for colds and flu, health concerns and health screenings.

Large provider network

You can choose any PCP from our large network of providers. Our network also includes specialists, hospitals, general dentists, dental specialists and pharmacies — giving you many options for your health care. Find a complete list of network providers at **myuhc.com/CommunityPlan** or call **1-800-941-4647**, TTY **711**.

Specialist services

Your coverage includes services from specialists. Specialists are doctors or nurses who are highly trained to treat certain conditions. You may need a referral from your PCP first. See page 27.

Medicines

Your plan covers prescription drugs for members of all ages. Members in NJ FamilyCare C and D, with some exceptions, will have a copay. Also covered: insulin, needles and syringes, birth control, coated aspirin for arthritis, iron pills and chewable vitamins.

Hospital services

You're covered for hospital stays. You're also covered for outpatient services. These are services you get in the hospital without spending the night.

Laboratory services

Covered services include tests and X-rays that help find the cause of illness.

Well-child visits

All well-child visits and immunizations are covered by your plan.

Maternity and pregnancy care

You are covered for doctor visits before and after your baby is born. That includes hospital stays. If needed, we also cover home visits after the baby is born.

Family planning

If you need Family Planning services, our network has providers that may be able to help you plan. These providers include Primary Care Providers (Internal Medicine, Family Practice, General Practice, Pediatrics), Adolescent Medicine providers, Providers at Federally Qualified Health Centers (FQHCs), Obstetrics & Gynecology providers, and providers of Women's Health. Other specialties that may be able to provide Family Planning services include providers of Adult Family Care, Certified Nurse Midwives, Community or Retail Pharmacists, Gynecologists, Gynecologic Oncologists, providers at HIV/AIDS Centers, Maternal Fetal Medicine providers, Nurse Practitioners for (Adult, Family, Obstetrics & Gynecology, Pediatrics), Physician Assistants, Registered Nurses, Reproductive Endocrinologists, providers at School-Based Health Service Programs, and Urologists. For a listing of in-network providers, visit **myuhc.com/CommunityPlan**.

Vision care

Your vision benefits include routine eye exams and glasses.

Dental care

NJ FamilyCare members have a comprehensive dental benefit (this includes MLTSS members).

Your Health Assessment

A Health Assessment is a short and easy survey that asks you simple questions about your lifestyle and your health. When you fill it out and mail it to us, we can get to know you better. This will allow us to better coordinate your care and to access the many benefits and services available to you.

Please take a few minutes to fill out the Health Assessment at **myuhc.com/CommunityPlan**. Click on the Health Assessment button on the right side of the page, after you register and/or login. Or call Member Services at **1-800-941-4647**, TTY **711**, to complete it by phone.

Member support

We want to make it as easy as possible for you to get the most from your health plan. As our member, you have many services available to you, including transportation and interpreters if needed. And if you have questions, there are many places to get answers.

Website offers 24/7 access to plan details

Go to **myuhc.com/CommunityPlan** to sign up for Web access to your account. This secure website keeps all of your health information in one place. In addition to plan details, the site includes useful tools that can help you:

- Complete your Health Assessment
- Find a medical provider, dentist (including a dentist who treats children under age 6) or pharmacy
- Search for a medicine in the Preferred Drug List
- Get benefit details
- Download a new Member Handbook

Member Services is available five days a week

Member Services can help with your questions or concerns. This includes:

- Understanding your benefits
- Help getting a replacement member ID card
- Finding a doctor or urgent care clinic
- Finding a dentist or dental specialist

Call **1-800-941-4647**, TTY **711**, 24 hours a day, 7 days a week.

Care Management program

If you have a chronic health condition, like asthma or diabetes, you may benefit from our Care Management program. We can help with a number of things, like scheduling doctor appointments and keeping all your providers informed about the care you get. To learn more, call **1-800-941-4647**, TTY **711**.

Transportation services are available for some members

As a UnitedHealthcare member, non-emergency transportation is offered to and from services as described in the member's plan of care.

We speak your language

If you speak a language other than English, we can provide translated printed materials at no cost to you, or we can provide an interpreter who can help you understand these materials. You'll find more information about Interpretive Services and Language Assistance in the section called Other Plan Details. Or call Member Services at **1-800-941-4647**, TTY **711**.

Si usted habla un idioma que no sea inglés, podemos proporcionar materiales impresos traducidos. O podemos proporcionar un intérprete que puede ayudar a entender estos materiales. Encontrará más información acerca de servicios de interpretación y asistencia lingüística en la sección Otros detalles del plan. O llame a Servicios para Miembros al **1-800-941-4647**, TTY **711**.

Emergencies

In case of emergency, call **911**

Important numbers

Member Services . . . . . **1-800-941-4647**, TTY **711**
24 hours a day, 7 days a week.

MLTSS Care Management . . . . . **1-800-645-9409**, TTY **711**

Behavioral Health Services . . . . . **1-800-941-4647**, TTY **711**
Members who are not DDD clients or not enrolled in MLTSS or FIDE SNP should call their local Medical Assistance Customer Service (MACC) office for mental health services. For substance use services for members who are not DDD clients or not in MLTSS or not FIDE SNP, call the NJ Addiction Services Hotline at **1-844-276-2777**, TTY **711**, 24 hours a day, 7 days a week.

Medication Assisted Treatment (MAT) and Office Based Addiction Treatment (OBAT)

MAT is the use of FDA approved medications, in combination with counseling and other therapies, for the treatment of substance use disorders. OBAT is a program designed to enhance access to and improve the use of MAT services by providing additional supports. These services can be coordinated with your Primary Care Provider (PCP).

If you are in need of MAT or OBAT services, or have questions about these or other health plan services, please call Member Services at **1-800-941-4647**, TTY **711**.

You can start using your pharmacy benefit right away

UnitedHealthcare has built a pharmacy network to make getting your prescriptions easier. Your plan covers prescription drugs. Members in NJ FamilyCare C and D with some exceptions, will have a copay. See your member handbook for details.

For certain prescriptions, you may need prior approval. Prior approval means we need to give permission before you get a specific drug. We will let you know if you need prior approval from us for any of your prescriptions. If you have a prescription to fill be sure to:

- Check that your prescription drug is on the preferred drug list (PDL), posted on our website at **myuhc.com/CommunityPlan**. This list will tell you which drugs are covered by your plan.
- Fill your prescriptions at one of the pharmacies in our network. You can find a list of these pharmacies on our website. Show your member ID card at the pharmacy when you get your prescriptions filled. This confirms your eligibility and helps the pharmacy in processing your claim.

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

1. Are your medicines included on the Preferred Drug List?

Yes

If your medicines are included on the Preferred Drug List, you're all set. Be sure to show your pharmacist your latest member ID card every time you get your prescriptions filled.

No

If your prescriptions are not on the Preferred Drug List, schedule an appointment with your doctor within the next 30 days. They may be able to help you switch to a drug that is on the Preferred Drug List. Your doctor can also help you ask for an exception if they think you need a brand name medicine that is not on the list and is medically necessary.

Not sure

View the Preferred Drug List online at **myuhc.com/CommunityPlan** (click on Find A Drug on the left side of the screen). You can also call Member Services. We're here to help.

2. Do you have a prescription?

When you have a prescription from your doctor, or need to refill your prescription, go to a network pharmacy. Show the pharmacist your member ID card. You can find a list of network pharmacies in the Provider Directory online at **myuhc.com/CommunityPlan**, or you can call Member Services.

3. Do you need to refill a drug that's not on the Preferred Drug List?

If you need refills of medicines that are not on the Preferred Drug List, you can get a temporary 5-day supply. To do so, visit a network pharmacy and show your member ID card. If you don't have your member ID card, you can show the pharmacist the information below. Talk to your doctor about your prescription options. Prior authorization might be needed.

Attention Pharmacist

Please process this UnitedHealthcare member's claim using:

BIN: 610494
Processor Control Number: 9999
Group: ACUNJ

If you receive a message that the member's medication needs a prior authorization or is not on our formulary, please call **OptumRx®** at **1-877-305-8952** for a transitional supply override.

Going to the doctor

Your Primary Care Provider (PCP)

We call the main doctor you see a Primary Care Provider, or PCP. When you see the same PCP over time, it's easier to develop a relationship with them. Each family member can have their own PCP, or you may all choose to see the same person. You will see your PCP for:

- Routine care, including yearly checkups
- Coordinating your care with a specialist
- Treatment for colds and flu
- Determining if a procedure is medical or dental
  - If the procedure can be better addressed by a dentist, and the member is not familiar with a dentist that is par with the plan, the member should call Member Services at **1-800-941-4647**, TTY **711** for the names of par dentists close to their home
- Advise first dental visit for all children, beginning at one year of age, and regular dental care throughout childhood (does not require a referral by PCP)
- Other health concerns

What is a network provider?

Network Providers have contracted with UnitedHealthcare to care for our members. You don't need to call us before seeing one of these providers. There may be times when you need to get services outside of our network. Call Member Services to learn if they are covered in full. You may have to pay for those services.

You have options

You can choose between many types of network providers for your PCP. Some types of PCPs include:

- Family doctor (also called a general practitioner) — cares for children and adults
- Gynecologist (GYN) — cares for women
- Internal medicine doctor (also called an internist) — cares for adults
- Nurse Practitioner (NP) — cares for children and adults
- Obstetrician (OB) — cares for pregnant women
- Pediatrician — cares for children
- Physician Assistant (PA) — cares for children and adults

Sometimes your PCP may use other health care workers in his or her practice such as nurse practitioners, or physician assistants to help him or her by participating in your care.

Learn more about network doctors

You can learn information about network doctors, such as name, address, phone, professional qualifications, specialty, medical school, residency, board certifications, and languages they speak, at **myuhc.com/CommunityPlan**, or by calling Member Services.

Choosing your PCP

If you've been seeing a doctor before becoming a UnitedHealthcare member, check to see if your doctor is in our network. If you're looking for a new PCP, consider choosing one who's close to your home or work. This may make it easier to get to appointments.

There are three ways to find the right PCP for you.

1. Look through our printed Provider Directory.
2. Use the Find-A-Doctor search tool at **myuhc.com/CommunityPlan**.
3. Call Member Services at **1-800-941-4647**, TTY **711**. We can answer your questions and help you find a PCP close to you.

Once you choose a PCP, call Member Services and let us know. We will make sure your records are updated. If you don't want to choose a PCP, UnitedHealthcare can choose one for you, based on your location and language spoken.

Going to the doctor

Having a PCP you know and who knows you is an important part of being a UnitedHealthcare member. The best way to get to know your PCP is to have a complete physical exam as soon as you can. This exam is also called a baseline exam. During this exam, your PCP will ask you questions about your health history. This exam can help find problems before they become serious. After meeting you and learning your health history, your PCP can better help you to stay healthy.

To schedule this exam, call your PCP's office and tell them this is your first visit. You should visit your PCP at least once a year. Your PCP will check your health and help you prevent disease. If you have any problems, call Member Services at **1-800-941-4647**, TTY **711**. Refer to page 24–26 for reasonable timeline for appointments.

Your UnitedHealthcare Care Manager can also help you with access arrangements if you are homebound.

Changing your PCP

We want you to be happy with your PCP. You have the right to change your PCP by calling Member Services at **1-800-941-4647**, TTY **711**. We can talk with you about why you want to change PCPs. We may even be able to help solve problems with your PCP. We can also send you a current provider directory.

If you do want to change doctors, Member Services can help you choose a new PCP at no cost to you. They will make sure you get a new UnitedHealthcare member ID card with your new PCP's name and phone number on it. We will tell you when you can start to see your new PCP, if necessary.

You may not be able to change to a specific PCP if that PCP doesn't treat members of your age group or isn't accepting new patients.

You can ask for your old PCP to send your medical records to you or your new PCP at no cost to you. Your signed enrollment application allows your old PCP to share medical records with your providers and UnitedHealthcare.

If you want to change your dentist you can call Member Services at **1-800-941-4647**, TTY **711** and they will be able to assist you in finding a new dentist.

Coordinating your care

Today's health care world requires you to visit many different providers; more than just your Primary Care Provider (PCP). That is why it is important that your care be coordinated to avoid duplication of services and medications. You will benefit when your primary doctor, health care providers and health plan coordinate your care, because they will be working together to give you the right care, at the right time and in the right setting. Your healthcare should feel like a partnership between you and your provider with a goal of keeping you healthy.

How can you help coordinate your care?

- Tell your PCP about all the specialists you see. Talk about any tests, treatments or medications that a specialist has prescribed or suggested.
- Ask your specialist to contact your PCP directly and send them a copy of your medical report and results. This helps avoid duplication of care or prevent problems when patients take two or more drugs that should not be used together.
- When you go to a specialist, ask for a copy of your medical report and results so you can bring them back to your PCP. It's a good idea to keep a copy for yourself.
- If emergency appointment visit was for a dental condition make sure to inform your dentist and schedule an appointment with your PCD
- If you have been to the emergency department or have had a hospital admission, make sure to inform your PCP. You can also ask the emergency room staff to send a copy of the visit to your PCP or PCD.
- If you have been admitted to the hospital or had an emergency room visit make sure to inform your PCP and schedule a follow-up. When you are in the hospital or emergency room you can also ask the hospital staff to send a copy of your medical information to your PCP.
- If your PCP or specialist orders a test, ask the provider when to expect your test results. Find out how you will get the test results; will it be by phone, letter or online on a secure patient portal. Be sure to learn about all your test results, even when results are normal. This helps you and your doctor to make sure no test results are missed.
- Bring a list of all medications you take (including vitamins, over the counter medications)

Remember you, your doctor and your health plan are all partners in your care.

Annual checkups

The importance of your annual checkup

You don't have to be sick to go to the doctor. In fact, yearly checkups with your PCP can help keep you healthy. In addition to checking on your general health, your PCP will make sure you get the screenings, tests and vaccines you need (child, adolescent and adult vaccines). And if there is a health problem, they're usually much easier to treat when caught early.

Here are some important preventive health screenings. How often you get a screening is based on your age and risk factors. Talk to your doctor about what's right for you.

For women

- Pap smear — helps detect cervical cancer
- Breast exam/Mammography — helps detect breast cancer; ages 35–39 for baseline Mammography; ages 40–74 Mammography
- Colorectal cancer screening — helps detect colon cancer; ages 50–75
- Height, Weight and Body Mass Index (BMI)

For men

- Testes exam — helps detect testicular cancer
- Prostate exam — helps detect prostate cancer; ages 50–75
- Colorectal cancer screening — helps detect colon cancer; ages 50–75
- Height, weight and body mass index (BMI)

Well-child visits – EPSDT

Well-child visits are a time for your PCP to see how your child is growing and developing. They will also give the needed screenings, like speech and hearing and vision tests, dental screenings, height, weight and Body Mass Index (BMI) percentile, immunizations and blood lead level testing during these visits. These routine visits are also a great time for you to ask any questions you have about your child's behavior and overall well-being, including:

- Eating
- Sleeping
- Dental/oral health
- Behavior
- Social interactions
- Physical activity
- Physical development
- Mental development
- Social Determinants of Health (SDOH)

EPSDT well-child schedule

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

3 to 5 days	15 months
1 month	18 months
2 months	24 months
4 months	30 months
6 months	3 years
9 months	4 years
12 months	Annually through age 21

Here are vaccines the doctor will likely give, and how they protect your child:

- **Hepatitis A and Hepatitis B:** prevent two common liver infections.
- **Rotavirus:** protects against a virus that causes severe diarrhea.
- **Diphtheria:** prevents a dangerous throat infection.
- **Tetanus:** prevents a dangerous nerve disease.
- **Pertussis:** prevents whooping cough.
- **HiB:** prevents childhood meningitis.
- **Meningococcal:** prevents bacterial meningitis.
- **Polio:** prevents a virus that causes paralysis.
- **MMR:** prevents measles, mumps and rubella.
- **Varicella:** prevents chickenpox.
- **Influenza:** protects against the flu virus.
- **Pneumococcal:** prevents ear infections, blood infections, pneumonia and bacterial meningitis.
- **HPV:** protects against a sexually transmitted virus that can lead to cervical cancer in women and genital warts in men based on age.

The CCD Link for Immunizations is **https://www.cdc.gov/vaccines**.

Making an appointment with your PCP and PCD

Call your doctor's (PCP) office directly. The number should be on your member ID card. When you call to make an appointment, be sure to tell the office the reason you need to see the doctor. This will help make sure you get the care you need, when you need it and adequate time with your PCP. If you do not know who your Primary Care Dentist (PCD) is, please call Member Services at **1-800-941-4647**, TTY **711** for assistance. This is how quickly you can expect to be seen:

How long it should take to see your PCP or dentist:	
Emergency Care	Immediately
Urgent Care (conditions that are not life-threatening)	Within 24 hours
Symptomatic Acute Care (you don't feel well, but aren't in danger)	Within 72 hours
Routine Care (preventive care like an annual exam or a checkup on medications)	Within 28 days
Specialist Referrals	Within 4 weeks or less
Urgent Specialty Care	Within 24 hours of referral
Baseline Physicals (for adults)	Within 180 calendar days of initial enrollment
Baseline Physicals (for children under 21 and adult DDD clients)	Within 90 days of initial enrollment, or for children as required by EPSDT (well-child) guidelines
Lab and Radiology Results	Within 24 hours in urgent or emergent cases. Within 10 business days for non-urgent or non-emergent cases.
Lab and Radiology Services	Three weeks for routine appointments; 48 hours for urgent care.

How long it should take to see your PCP or dentist:	
Prenatal Care (pregnant women)	Within: • 3 weeks of a positive pregnancy test (home or lab) • 3 days of identification of high risk • 7 days of request in 1st and 2nd trimester • 3 days of 1st request in 3rd trimester
Routine Physicals	Within 4 weeks for routine physicals needed for school, camp, work, etc.
Waiting Time in Office	Less than 45 minutes
Initial Pediatric Appointments	Within 3 months of enrollment; UnitedHealthcare will call you to arrange an appointment
Dental Appointments	• A baseline dental exam is recommended within 2 weeks of enrollment • Emergency dental treatment within 48 hours of onset of pain, facial swelling, dental injury, uncontrolled bleeding or infection involving teeth or gums (less for a more serious condition). See “Emergency dental care” on page 32 for more information and make sure to get follow-up treatment by a dental provider. • Urgent care appointments within 3 days • Routine, non-symptomatic appointments within 30 days Please review the benefit chart beginning on page 36 for your specific coverage.
Mental Health/Substance Use Appointments (for DDD clients and MLTSS members only)	• Emergency services: immediately • Urgent care appointments: within 24 hours • Routine care appointments: within 10 days

How long it should take to see your PCP or dentist:	
SSI and New Jersey Care (ABD elderly and disabled enrollees)	UnitedHealthcare will call to offer an initial PCP visit within 45 days of your effective date of enrollment. If you have special needs, we will call you within 10 business days of enrollment and offer an expedited appointment.

Preparing for your PCP appointment

Before the visit

1. Go in knowing what you want to get out of the visit (relief from symptoms, a referral to a specialist, specific information, etc.).
2. Make note of any new symptoms and when they started.
3. Make a list of any drugs, herbs or vitamins you take on a regular basis.

During the visit

When you are with the doctor, feel free to:

- Ask questions
- Take notes if it helps you remember
- Ask the doctor to speak slowly or explain anything you don't understand
- Ask for more information about any medicines, treatments or conditions
- Make sure you understand the final treatments and whether you agree with the treatment plan

If you need care and your provider's office is closed

Call your PCP if you need care that is not an emergency. Your provider's phone is answered 24 hours a day, 7 days a week. Your provider or someone from the office will help you make the right choice for your care.

You may be told to:

- Go to an after-hours clinic or urgent care center
- Go to the office in the morning
- Go to the emergency room (ER)
- Get medicine from your pharmacy

Referrals and specialists

A referral is when your PCP says you need to go to another doctor who focuses on caring for a certain part of the body or treating a specific condition. This other doctor is called a specialist. You must see your PCP before you see a specialist. If your doctor wants you to see a specialist that you do not want to see, you can ask your PCP to give you the name of another specialist. If the visit is urgent your PCP may be able to call and schedule the appointment for you. A couple of examples of specialists include:

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

You do not need a referral from your PCP for:

- Emergency services
- OB/GYN
- Optometrists
- Dermatologists
- Mental health/substance use professionals
- Chiropractors
- Dentists, including pediatric dentists or other dental specialists. You must receive preapproval to be treated by an out-of-network provider.

Sometimes people with certain conditions would be better off if a specialist serves as their PCP. If you think you'd be better off with a specialist as your PCP, call Member Services at **1-800-941-4647**, TTY **711**. You can also ask your PCP or UnitedHealthcare for a standing referral. A standing referral will let you see a specialist whenever you have to, without talking to your PCP first. Please contact your Care Manager if you want to set up a standing referral.

If you think you need a specialist or need to go to a specialty care center all the time, you can also get a standing referral to a specialist or specialty care center. If you have any questions about referrals, call Member Services at **1-800-941-4647**, TTY **711**. If UnitedHealthcare does not have a doctor with the training and experience that you need, we will arrange for you to see an out-of-network provider. We will work with your PCP to get you this referral. You will not pay for this care.

Your specialists (or an approved back-up) will be available to you 24 hours a day, 7 days a week. You can call your specialists any time you have a health question or problem, no matter what time it is.

To get self-referral services, you may call a provider listed in the Self-Referral section of our provider directory. If you have any questions, please call Member Services at **1-800-941-4647**, TTY **711**.

Getting a second opinion

A second opinion is when you want to see a second physician or dentist for the same health or dental concern. You can get a second opinion from a network provider for any of your covered benefits. This is your choice. You are not required to get a second opinion. If the type of doctor or dentist needed is not available in-network for a second opinion, we will arrange for a second opinion out-of-network at no cost to you. Prior authorization may be needed. Please call Member Services at **1-800-941-4647**, TTY **711** for assistance.

Prior authorizations

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

You do not need prior authorization for advanced imaging services that take place in an emergency room, observation unit, urgent care facility or during an inpatient stay. You do not need a prior authorization for emergencies. You also do not need prior authorization to see a women's health care provider for women's health services or if you are pregnant.

If a change in MCO or Fee-for-Service enrollment occurs, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the MCO of new enrollment. This prior authorization shall be honored for as long as it is active or for a period of six months, whichever is longer.

A prior authorization may be needed

Some services that need prior authorization include:

- Hospital admissions
- Home health care services
- Certain outpatient imaging procedures, including MRIs, MRAs, CT scans and PET scans
- Sleep studies
- Medications that are medically necessary but not on the preferred drug list
- Certain dental services — see Dental services table, page 40, for more information
- If the prior authorization has expired, a new request for prior authorization will be required

Continued care if your PCP leaves the network

Sometimes PCPs leave the network. If this happens to your PCP, you will receive a letter from us letting you know. Sometimes UnitedHealthcare will pay for you to get covered services from doctors for up to four months after they leave the network. You may be able to get continued care and treatment when your doctor leaves the network if you are being actively treated for a serious medical problem. For example, if you are getting chemotherapy for cancer, the continuation of care with the PCP who leaves the network is for one year and up to six weeks after delivery for pregnant women whose doctor leaves the network. To ask for this, please call your doctor. Ask them to request an authorization for continued care and treatment from UnitedHealthcare.

If you need care when out of town

UnitedHealthcare will pay for routine care out-of-area only if:

- You call your PCP first and he or she says that it is important that you get care before you return home

Transportation services

UnitedHealthcare will pay for emergency transportation for all members. Sometimes you may need a ride to the doctor or dentist because you have a severe injury or illness. When this happens, your PCP will work with FFS. To ask for these services, call ModivCare at 1-866-527-9933 or TTY 1-866-288-3133.

Hospitals and emergencies

Emergency care

Hospital emergency rooms are there to offer emergency treatment for trauma, serious injury and life-threatening symptoms. Reasons to go to the ER include but are not limited to:

- Serious illness
- Broken bones
- Difficulty breathing
- Chest pain
- Weakness on one side of the body
- Severe bleeding
- Slurred speech
- Sudden vision problems
- Poisoning
- Severe cuts or burns
- Going into labor

UnitedHealthcare covers any emergency care you need throughout the United States and its territories including the costs of emergency screening exams when the condition appears to be an emergency to the average person. You do not need prior authorization for emergency screening exams whether in-network or out-of-network. Within 24 hours after your visit to the emergency room, call Member Services at **1-800-941-4647**, TTY **711**. You should also call your PCP and let them know about your visit so they can provide follow-up care if needed.

Don't wait

If you need emergency care, call 911 or go to the nearest hospital.

Urgent Care

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

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

If you or your children 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.

Planning ahead

It's good to know what urgent care clinic is nearest to you. You can find a list of urgent care clinics in your Provider Directory. Or you can call Member Services at **1-800-941-4647**, TTY **711**.

Hospital services

There are times when your health may require you to go to the hospital. There are both inpatient and outpatient hospital services.

Outpatient services include X-rays, lab tests and minor surgeries. Your PCP will tell you if you need outpatient services. Your doctor's office can help you schedule them.

Inpatient services require you to stay overnight at the hospital. These can include serious illness, surgery or having a baby.

Inpatient services require you to be admitted (called a hospital admission) to the hospital. The hospital will contact UnitedHealthcare and ask for authorization for your care. 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. You can also ask the hospital staff to let your PCP know that you are in the hospital.

Going to the hospital

You should go to the hospital only if you need emergency care or if your doctor told you to go.

Emergency dental care

Emergency dental services are covered by your plan. Please contact an in-network dental provider unless you are experiencing facial trauma including broken bones and dislocated jaw or severe swelling/infection which may require an emergency room visit. Out-of-network providers may be used if an in-network provider is not available.

For additional information contact Member Services at **1-800-941-4647**, TTY **711**. You can also call Member Services if you have not selected a dentist or cannot locate a dentist.

Post-stabilization services

Post-stabilization services are covered and provided without prior authorization. These are services that are medically necessary after an emergency medical condition has been stabilized.

No medical coverage outside of United States

If you are outside of the United States and need medical care, any health care services you receive will not be covered by UnitedHealthcare. NJ FamilyCare cannot pay for any medical services you get outside of the United States.

Pharmacy

Prescription drugs

Your benefits include prescription drugs

UnitedHealthcare covers hundreds of prescription drugs from hundreds of pharmacies. The full list of covered drugs is included in the Preferred Drug List. You can fill your prescription at any in-network pharmacy. All you have to do is show your member ID card.

What is the Preferred Drug List?

This is a list of drugs covered under your plan. You can find the complete list in your Preferred Drug List, or online at myuhc.com/CommunityPlan.

Generic and brand name drugs

UnitedHealthcare requires all members to use generic drugs. Generic drugs have the same ingredients as brand name drugs — they often cost less, but they work the same.

In some cases, a limited number of brand name drugs are covered. These are limited to certain classes (or types) of drugs. Some of these may require prior authorization by UnitedHealthcare. See our preferred drug list online, or call Member Services at **1-800-941-4647**, TTY **711**, for rules that apply.

Your plan now allows you to get a 90 day supply of select medications at the retail pharmacy. With a 90 day supply, you won't need to get a refill every month. Talk with your doctor to see if your medications are included in this benefit; your doctor can write you a new prescription for a 90 day supply of the same medication you are taking now. For more information speak with your doctor, pharmacist, or call Member Services at **1-800-941-4647**, TTY **711**.

Some drugs require your doctor to get a prior authorization before the prescription is filled. Your doctor must call UnitedHealthcare for approval before you can get any drugs that need a prior authorization. UnitedHealthcare will decide whether to give a prior authorization within 24 hours of getting all the information we need. UnitedHealthcare will authorize a 72-hour supply of the prescribed medication on or off our formulary to cover you while we're making our decision.

Changes to the Preferred Drug List

The list of covered drugs is reviewed on a regular basis and may change when new generic drugs are available. There are some members who may have to pay a small amount (called a copay) for their prescriptions. If you have a copay, the amount is on the front of your member ID card.

Over-the-Counter (OTC) medicines

UnitedHealthcare also covers many over-the-counter (OTC) medications. An in-network provider must write you a prescription for the OTC medication you need. The supply is limited to 30 days. Then all you have to do is take your prescription and member ID card into any network pharmacy to fill the prescription at no cost to you. OTC medications include:

- Pain relievers
- Cough medicine
- First-aid cream
- Cold medicine
- Contraceptives
- Fluoride rinses

For a complete list of covered OTC medicines, go to **myuhc.com/CommunityPlan**. Or call Member Services at **1-800-941-4647**, TTY **711**.

Injectable medicines

Injectable medications are medicines given by shot, and they are a covered benefit. Your PCP can have the injectable medication delivered either to the doctor's office or to your home. In some cases, your doctor will write you a prescription for an injectable medication (like insulin) that you can fill at a pharmacy.

Pharmacy home

Some UnitedHealthcare members will be assigned to a pharmacy home (lock-in program). In this case, members must fill prescriptions at a single pharmacy. This is based on prior medication use, including overuse of pharmacy benefit, narcotics, pharmacy locations and other information.

Members of this program will be sent a letter with the name of the pharmacy and/or other provider type for a reasonable period of time that they are required to use. If you get this letter, you have 30 days from the date of the letter to request a change of pharmacy. In special cases, you may be able to request a pharmacy change after 30 days. You will still only be able to use one pharmacy.

To change your pharmacy, call Member Services at **1-800-941-4647**, TTY **711**. We will make sure you can get the medicines you need, in case of an emergency. Please note: A 72-hour emergency supply at other pharmacies may be allowed.

If you get a letter assigning you to a pharmacy home and you don't agree with this decision, you have the right to appeal that decision. You can do this by calling Member Services at **1-800-941-4647**, TTY **711**, or send your request to:

Grievances and Appeals
UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131

If you are enrolled in NJ FamilyCare A or NJ FamilyCare ABP you can ask for a Fair Hearing. You have 20 calendar days from the date of the letter assigning you to a pharmacy home to request a Fair Hearing. The request for a Fair Hearing must be filed at the same time as the appeal.

Benefits

Benefits summary

The New Jersey Department of Human Services, Division of Medical Assistance and Health Services administers the benefits for recipients of FFS and NJ FamilyCare A, ABP, B, C and D and MLTSS.

The tables on the next few pages show what services UnitedHealthcare and FFS covers. Members will need to show both their member ID card and their Health Benefits ID (HBID) card for services listed as "FFS." If you have questions about coverage or getting services, call Member Services at **1-800-941-4647**, TTY **711**.

UnitedHealthcare does not discriminate on the basis of gender identity or expression, or on the basis the member is transgender. UnitedHealthcare will also not deny, cancel, refuse to renew or limit coverage, or deny a claim, for Covered Services due to gender identity or expression, or for the reason that the covered person is transgender. Those Covered Services include but are not limited to:

- Health care services related to gender transition if coverage is available under the NJ FamilyCare contract when the services are not related to gender transition. This includes but is not limited to hormone therapy, hysterectomy, mastectomy, and vocal training.
- Health care services that are ordinarily or exclusively available to individuals of one sex when the denial or limitation is due only to the fact that the person is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, gender transition

Summary of benefits

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Abortions	Covered by FFS. Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests.	Covered by FFS. Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests.	Covered by FFS. Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests.	Covered by FFS. Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests.
Acupuncture	Covered.	Covered.	Covered.	Covered.
Autism Services	Covered by MCO and FFS. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include physical, occupational, and speech therapies; augmentative and alternative communication services and devices; sensory integration services; developmental and relationship based interventions and Applied Behavior Analysis (ABA) treatment.	Covered by MCO and FFS. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include physical, occupational, and speech therapies; augmentative and alternative communication services and devices; sensory integration services; developmental and relationship based interventions and Applied Behavior Analysis (ABA) treatment.	Covered by MCO and FFS. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include physical, occupational, and speech therapies; augmentative and alternative communication services and devices; sensory integration services; developmental and relationship based interventions and Applied Behavior Analysis (ABA) treatment.	Covered by MCO and FFS. Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include physical, occupational, and speech therapies; augmentative and alternative communication services and devices; sensory integration services; developmental and relationship based interventions and Applied Behavior Analysis (ABA) treatment.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Blood and Blood Products	Covered. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.	Covered. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.	Covered. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.	Covered. Whole blood and derivatives, as well as necessary processing and administration costs, are covered. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.
Bone Mass Measurement	Covered. Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.	Covered. Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.	Covered. Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.	Covered. Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.
Cardiovascular Screenings	Covered. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.	Covered. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.	Covered. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.	Covered. For all persons 20 years of age and older, annual cardiovascular screenings are covered. More frequent testing is covered when determined to be medically necessary.
Chiropractic Services	Covered. Covers manipulation of the spine.	Covered. Covers manipulation of the spine.	Covered. Covers manipulation of the spine.	Covered. Covers manipulation of the spine.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Colorectal Screening	Covered. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 50 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.	Covered. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 50 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.	Covered. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 50 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.	Covered. Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 50 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.
• **Barium Enema**	Covered. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.	Covered. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.	Covered. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.	Covered. When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.
• **Colonoscopy**	Covered. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.	Covered. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.	Covered. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.	Covered. Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.
• **Fecal Occult Blood Test**	Covered. Covered once every 12 months.	Covered. Covered once every 12 months.	Covered. Covered once every 12 months.	Covered. Covered once every 12 months.
• **Flexible Sigmoidoscopy**	Covered. Covered once every 48 months.	Covered. Covered once every 48 months.	Covered. Covered once every 48 months.	Covered. Covered once every 48 months.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Dental Services	Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Examples of covered services include (but are not limited to): oral evaluations (examinations); X-rays and other diagnostic imaging; dental cleaning (prophylaxis); topical fluoride treatments; (Continues on next page.)	Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Examples of covered services include (but are not limited to): oral evaluations (examinations); X-rays and other diagnostic imaging; dental cleaning (prophylaxis); topical fluoride treatments; (Continues on next page.)	Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Examples of covered services include (but are not limited to): oral evaluations (examinations); X-rays and other diagnostic imaging; dental cleaning (prophylaxis); topical fluoride treatments; (Continues on next page.)	Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity. Examples of covered services include (but are not limited to): oral evaluations (examinations); X-rays and other diagnostic imaging; dental cleaning (prophylaxis); topical fluoride treatments; (Continues on next page.)

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Dental Services (continued)	Examples of covered services continued: fillings; crowns; root canal therapy; scaling and root planing; complete and partial dentures; oral surgical procedures (to include extractions); intravenous anesthesia/sedation (where medically necessary for oral surgical procedures). Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. (Continues on next page.)	Examples of covered services continued: fillings; crowns; root canal therapy; scaling and root planing; complete and partial dentures; oral surgical procedures (to include extractions); intravenous anesthesia/sedation (where medically necessary for oral surgical procedures). Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. (Continues on next page.)	Examples of covered services continued: fillings; crowns; root canal therapy; scaling and root planing; complete and partial dentures; oral surgical procedures (to include extractions); intravenous anesthesia/sedation (where medically necessary for oral surgical procedures). Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. (Continues on next page.)	Examples of covered services continued: fillings; crowns; root canal therapy; scaling and root planing; complete and partial dentures; oral surgical procedures (to include extractions); intravenous anesthesia/sedation (where medically necessary for oral surgical procedures). Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year. Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. (Continues on next page.)

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Dental Services (continued)	Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity. **Please check with your dentist to understand which services may require prior authorization.**	Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity. **Please check with your dentist to understand which services may require prior authorization.**	Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity. **Please check with your dentist to understand which services may require prior authorization.** **NJ FamilyCare C and D members have a $5 copay per dental visit (except for diagnostic and preventive services).**	Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity. **Please check with your dentist to understand which services may require prior authorization.** **NJ FamilyCare C and D members have a $5 copay per dental visit (except for diagnostic and preventive services).**

Table of contents

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Diabetes Screenings	Covered. Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. Diabetes Prevention Program (DPP), Diabetes Self-management Education (DSME and Medical Nutritional Therapy (MNT).	Covered. Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. Diabetes Prevention Program (DPP), Diabetes Self-management Education (DSME and Medical Nutritional Therapy (MNT).	Covered. Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. Diabetes Prevention Program (DPP), Diabetes Self-management Education (DSME and Medical Nutritional Therapy (MNT).	Covered. Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. Diabetes Prevention Program (DPP), Diabetes Self-management Education (DSME and Medical Nutritional Therapy (MNT).

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Diabetes Supplies	Covered. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.	Covered. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.	Covered. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.	Covered. Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.
Diabetes Testing and Monitoring	Covered. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations.	Covered. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations.	Covered. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations.	Covered. Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations.
Diagnostic and Therapeutic Radiology and Laboratory Services	Covered. Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays.	Covered. Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays.	Covered. Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays.	Covered. Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Durable Medical Equipment (DME)	Covered.	Covered.	Covered.	Covered.
Emergency Care	Covered. Covers emergency department and physician services.	Covered. Covers emergency department and physician services.	Covered. Covers emergency department and physician services. **NJ FamilyCare C members have a $10 copayment.**	Covered. Covers emergency department and physician services. **NJ FamilyCare D members have a $35 copayment.**

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
EPSDT (Early and Periodic Screening Diagnosis and Treatment)	Covered. Coverage includes (but is not limited to) well child care, preventive screenings, medical examinations,, dental, vision and hearing screenings and services (as well as any treatment identified as necessary as a result of examinations or screenings), immunizations(including the full childhood immunization schedule), lead screening, and private duty nursing services. Private duty nursing is covered for eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need.	Covered. For NJ FamilyCare B, C, and D members, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. **For NJ FamilyCare B, C, and D members, coverage for treatment services identified as necessary through an examination is limited to those services that are available under the plan's benefit package, or specified services under the FFS program.**	Covered. For NJ FamilyCare B, C, and D members, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. **For NJ FamilyCare B, C, and D members, coverage for treatment services identified as necessary through an examination is limited to those services that are available under the plan's benefit package, or specified services under the FFS program.**	Covered. For NJ FamilyCare B, C, and D members, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. **For NJ FamilyCare B, C, and D members, coverage for treatment services identified as necessary through an examination is limited to those services that are available under the plan's benefit package, or specified services under the FFS program.**

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Family Planning Services and Supplies	Covered. The MCO shall reimburse family planning services provided by non-participating network providers based on the Medicaid fee schedule. The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to: sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing. (Continues on next page.)	Covered. The MCO shall reimburse family planning services provided by non-participating network providers based on the Medicaid fee schedule. The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to: sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing. (Continues on next page.)	Covered. The MCO shall reimburse family planning services provided by non-participating network providers based on the Medicaid fee schedule. The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to: sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing. (Continues on next page.)	Covered. The MCO shall reimburse family planning services provided by non-participating network providers based on the Medicaid fee schedule. The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to: sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing. (Continues on next page.)

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Family Planning Services and Supplies (continued)	Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. **Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).**	Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. **Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).**	Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. **Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).**	Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling. **Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).**
Federally Qualified Health Centers (FQHC)	Covered. Includes outpatient and primary care services from community-based organizations.	Covered. Includes outpatient and primary care services from community-based organizations.	Covered. Includes outpatient and primary care services from community-based organizations.	Covered. Includes outpatient and primary care services from community-based organizations.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Hearing Services/ Audiology	Covered. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.	Covered. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.	Covered. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.	Covered. Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are covered.
Home Health Agency Services	Covered. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.	Covered. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.	Covered. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.	Covered. Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Hospice Care Services	Covered. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. – Covered in the community as well as in institutional settings – Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care **NOTE:** **Any care unrelated to the enrollee's terminal condition is covered in the same manner as it would be under other circumstances.**	Covered. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. – Covered in the community as well as in institutional settings – Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care **NOTE:** **Any care unrelated to the enrollee's terminal condition is covered in the same manner as it would be under other circumstances.**	Covered. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. – Covered in the community as well as in institutional settings – Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care **NOTE:** **Any care unrelated to the enrollee's terminal condition is covered in the same manner as it would be under other circumstances.**	Covered. Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling. – Covered in the community as well as in institutional settings – Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care **NOTE:** **Any care unrelated to the enrollee's terminal condition is covered in the same manner as it would be under other circumstances.**

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Immunizations	Covered. Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.	Covered. Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.	Covered. Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.	Covered. Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are covered. The full childhood immunization schedule is covered as a component of EPSDT.
Inpatient Hospital Care	Covered. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.	Covered. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.	Covered. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.	Covered. Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, X-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
• Acute Care	Covered. Includes room and board; nursing and other related services; use of hospital/ Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).	Covered. Includes room and board; nursing and other related services; use of hospital/ Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).	Covered. Includes room and board; nursing and other related services; use of hospital/ Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).	Covered. Includes room and board; nursing and other related services; use of hospital/ Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).
• Psychiatric	**For coverage details, please refer to the Behavioral Health chart.**	**For coverage details, please refer to the Behavioral Health chart.**	**For coverage details, please refer to the Behavioral Health chart.**	**For coverage details, please refer to the Behavioral Health chart.**
Mammograms	Covered. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.	Covered. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.	Covered. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.	Covered. Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Maternal and Child Health Services	Covered. Covers prenatal and postpartum care including childbirth education, doula services, lactation supplies, breastfeeding support services, and related newborn care and hearing screenings, including midwifery care, CenteringPregnancy, LARC including immediate postpartum LARC (Long-Acting Reversible Contraception), and all dental services (to include but not limited to additional dental preventive care and medically necessary dental treatment services). Also covers childbirth education, doula care, lactation support. Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit.	Covered. Covers prenatal and postpartum care including childbirth education, doula services, lactation supplies, breastfeeding support services and related newborn care and hearing screenings, including midwifery care, CenteringPregnancy, LARC including immediate postpartum LARC (Long-Acting Reversible Contraception), and all dental services (to include but not limited to additional dental preventive care and medically necessary dental treatment services). Also covers childbirth education, doula care, lactation support. Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit.	Covered. Covers prenatal and postpartum care including childbirth education, doula services, lactation supplies, breastfeeding support services and related newborn care and hearing screenings, including midwifery care, CenteringPregnancy, LARC including immediate postpartum LARC (Long-Acting Reversible Contraception), and all dental services (to include but not limited to additional dental preventive care and medically necessary dental treatment services). Also covers childbirth education, doula care, lactation support. Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit	Covered. Covers prenatal and postpartum care including childbirth education, doula services, lactation supplies, breastfeeding support services and related newborn care and hearing screenings, including midwifery care, CenteringPregnancy, LARC including immediate postpartum LARC (Long-Acting Reversible Contraception), and all dental services (to include but not limited to additional dental preventive care and medically necessary dental treatment services). Also covers childbirth education, doula care, lactation support. Breastfeeding equipment, including breast pumps and accessories, are covered as a DME benefit.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Medical Day Care (Adult Day Health Services)	Covered. A program that provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory (outpatient) care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.
Nurse Midwife Services	Covered.	Covered.	Covered. $5 copayment for each visit (except for prenatal care visits).	Covered. $5 copayment for each visit (except for prenatal care visits).
Nursing Facility Services	Covered. Members may have patient pay liability.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.
• Long Term (Custodial Care)	Covered. Covered for those who need Custodial Level of Care (MLTSS). Members may have patient pay liability.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
• Nursing Facility (Hospice)	Covered. Hospice care can be covered in a Nursing Facility setting. ***See Hospice Care Services.**	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.
• Nursing Facility (Skilled)	Covered. Includes coverage for Rehabilitative Services that take place in a Nursing Facility setting.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.
• Nursing Facility (Special Care)	Covered. Care in a Special Care Nursing Facility (SCNF) or a separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility is covered for members who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Organ Transplants	Covered. Covers medically necessary organ transplants including (but not limited to): liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.	Covered. Covers medically necessary organ transplants including (but not limited to): liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.	Covered. Covers medically necessary organ transplants including (but not limited to): liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.	Covered. Covers medically necessary organ transplants including (but not limited to): liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.
Outpatient Surgery	Covered.	Covered.	Covered.	Covered.
Outpatient Hospital/Clinic Visits	Covered.	Covered.	Covered. **$5 copayment per visit (no copayment if the visit is for preventive services).**	Covered. **$5 copayment per visit (no copayment if the visit is for preventive services).**
Outpatient Rehabilitation (Occupational Therapy, Physical Therapy, Speech Language Pathology)	Covered. Covers physical therapy, occupational therapy, speech pathology, and cognitive rehabilitation therapy.	Covered. Covers physical, occupational, and speech/language therapy. **For NJ FamilyCare B, C, and D members, limited to 60 days per therapy per calendar year.**	Covered. Covers physical, occupational, and speech/language therapy. **For NJ FamilyCare B, C, and D members, limited to 60 days per therapy per calendar year.**	Covered. Covers physical, occupational, and speech/language therapy. **For NJ FamilyCare B, C, and D members, limited to 60 days per therapy per calendar year.**

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Pap Smears and Pelvic Exams	Covered. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.	Covered. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.	Covered. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.	Covered. Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Personal Care Assistance	Covered. Covers health-related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.	Not covered for NJ FamilyCare B, C, or D members.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Podiatry	Covered. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.	Covered. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.	Covered. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. $5 copayment per visit for NJ FamilyCare C and D members. Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.	Covered. Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. $5 copayment per visit for NJ FamilyCare C and D members. Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Prescription Drugs	Covered. Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are covered.	Covered. Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are covered.	Covered. Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are Covered. **For NJ FamilyCare C and D members, there is a $1 copayment for generic drugs, and a $5 copayment for brand name drugs.**	Covered. Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are Covered. **For NJ FamilyCare C and D members, there is a $1 copayment for generic drugs, and a $5 copayment for brand name drugs.**

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Physician Services – Primary and Specialty Care	Covered. Covers medically necessary services and certain preventive services in outpatient settings.	Covered. Covers medically necessary services and certain preventive services in outpatient settings.	Covered. Covers medically necessary services and certain preventive services in outpatient settings. **$5 copayment for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment, age-appropriate immunizations; prenatal care; and pap smears, when appropriate).**	Covered. Covers medically necessary services and certain preventive services in outpatient settings. **$5 copayment for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment, age-appropriate immunizations; prenatal care; and pap smears, when appropriate).**
Private Duty Nursing	Covered. Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. **Private Duty Nursing is only available to EPSDT beneficiaries under 21 years of age, and to members with MLTSS (of any age).**	Covered. Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. **Private Duty Nursing is only available to EPSDT beneficiaries under 21 years of age, and to members with MLTSS (of any age).**	Covered. Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. **Private Duty Nursing is only available to EPSDT beneficiaries under 21 years of age, and to members with MLTSS (of any age).**	Covered. Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need. **Private Duty Nursing is only available to EPSDT beneficiaries under 21 years of age, and to members with MLTSS (of any age).**

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Prostate Cancer Screening	Covered. Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.	Covered. Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.	Covered. Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.	Covered. Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.
Prosthetics and Orthotics	Covered. Coverage includes (but is not limited to) arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.	Covered. Coverage includes (but is not limited to) arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.	Covered. Coverage includes (but is not limited to) arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.	Covered. Coverage includes (but is not limited to) arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.
Renal Dialysis	Covered.	Covered.	Covered.	Covered.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Routine Annual Physical Exams	Covered.	Covered.	Covered. **No copayments.**	Covered. **No copayments.**
Sex Assault Examinations	Covered by FFS.	Covered by FFS.	**Covered by FFS.**	**Covered by FFS.**
Smoking/Vaping Cessation	Covered. Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges. The following resources are available to support you in quitting smoking/vaping: (Continues on next page.)	Covered. Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges. The following resources are available to support you in quitting smoking/vaping: (Continues on next page.)	Covered. Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges. The following resources are available to support you in quitting smoking/vaping: (Continues on next page.)	Covered. Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges. The following resources are available to support you in quitting smoking/vaping: (Continues on next page.)

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Smoking/Vaping Cessation (continued)	**NJ Quitline:** Design a program that fits your needs and get support from counselors. Call toll free **1-866-NJ-STOPS (1-866-657-8677)** (TTY **711**), Monday through Friday, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., ET. The program supports 26 different languages. Learn more at **njquitline.org**.	**NJ Quitline:** Design a program that fits your needs and get support from counselors. Call toll free **1-866-NJ-STOPS (1-866-657-8677)** (TTY **711**), Monday through Friday, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., ET. The program supports 26 different languages. Learn more at **njquitline.org**.	**NJ Quitline:** Design a program that fits your needs and get support from counselors. Call toll free **1-866-NJ-STOPS (1-866-657-8677)** (TTY **711**), Monday through Friday, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., ET. The program supports 26 different languages. Learn more at **njquitline.org**.	**NJ Quitline:** Design a program that fits your needs and get support from counselors. Call toll free **1-866-NJ-STOPS (1-866-657-8677)** (TTY **711**), Monday through Friday, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., ET. The program supports 26 different languages. Learn more at **njquitline.org**.
Transportation (Emergency) (Ambulance, Mobile Intensive Care Unit)	Covered. Coverage for emergency care, including (but not limited to) ambulance and Mobile Intensive Care Unit.	Covered. Coverage for emergency care, including (but not limited to) ambulance and Mobile Intensive Care Unit.	Covered. Coverage for emergency care, including (but not limited to) ambulance and Mobile Intensive Care Unit.	Covered. Coverage for emergency care, including (but not limited to) ambulance and Mobile Intensive Care Unit.

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Transportation (Non-Emergent) (Non-Emergency Ambulance, Medical Assistance Vehicles/MAV, Livery, Clinic)	Covered by FFS. Medicaid Fee-for-Service covers all non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life sup-port (BLS) ambulance (stretcher). Livery trans-portation services, such as bus and train fare or pass-es, car service and reim-bursement for mileage, are also Covered. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimburse-ment are covered. (Continues on next page.)	Covered by FFS. Medicaid Fee-for-Service covers non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). Livery trans-portation services, such as bus and train fare or passes, car service and reim-bursement for mileage, are also Covered. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimburse-ment are covered (Continues on next page.)	Covered by FFS. Medicaid Fee-for-Service covers non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). Livery trans-portation services, such as bus and train fare or passes, car service and reim-bursement for mileage, are also Covered. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimburse-ment are covered. (Continues on next page.)	Covered by FFS. Medicaid Fee-for-Service covers non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). Livery trans-portation services, such as bus and train fare or passes, car service and reim-bursement for mileage, are also Covered. For COVID-related services, livery/car transportation services, ambulatory, ambulatory with assistance, wheelchair, stretcher, mass transit/bus passes, and mileage reimburse-ment are covered. (Continues on next page.)

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Transportation (Non-Emergent) (Non-Emergency Ambulance, Medical Assistance Vehicles/MAV, Livery, Clinic) (continued)	May require medical orders or other coordination by the health plan, PCP, or providers. ModivCare Transportation services are covered for NJ FamilyCare B, C, or D members. All transportation including livery is available for all members including B, C and D.	May require medical orders or other coordination by the health plan, PCP, or providers. ModivCare Transportation services are covered for NJ FamilyCare B, C, or D members. All transportation including livery is available for all members including B, C and D.	May require medical orders or other coordination by the health plan, PCP, or providers. ModivCare Transportation services are covered for NJ FamilyCare B, C, or D members. All transportation including livery is available for all members including B, C and D.	May require medical orders or other coordination by the health plan, PCP, or providers. ModivCare Transportation services are covered for NJ FamilyCare B, C, or D members. All transportation including livery is available for all members including B, C and D.
Urgent Medical Care	Covered. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).	Covered. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).	Covered. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse). **NOTE: There may be a $5 copayment for urgent medical care provided by a physician, optometrist, dentist, or nurse practitioner.**	Covered. Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse). **NOTE: There may be a $5 copayment for urgent medical care provided by a physician, optometrist, dentist, or nurse practitioner.**

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Vision Care Services	Covered. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration.	Covered. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration.	Covered. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration. **$5 copayment per visit for Optometrist services.**	Covered. Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses. Yearly exams for diabetic retinopathy are covered for member with diabetes. A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma. Certain additional diagnostic tests are covered for members with age-related macular degeneration. **$5 copayment per visit for Optometrist services.**

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
• Corrective Lenses	Covered. Covers 1 pair of lenses/ frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.	Covered. Covers 1 pair of lenses/ frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.	Covered. Covers 1 pair of lenses/ frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.	Covered. Covers 1 pair of lenses/ frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.

Behavioral health (mental health/substance use) services

Most NJ FamilyCare members can get their Mental Health/Substance Use Services from any NJ FamilyCare approved provider by using their NJ FamilyCare/HBID card. To access these services, call your local Medical Assistance Customer Center (MACC) or call Member Services at **1-800-941-4647**, TTY **711**. Some services related to the diagnosis and treatment of a mental health or substance use disorder are covered by UnitedHealthcare and will need to be coordinated between the NJ FamilyCare approved provider and UnitedHealthcare. This includes certain drugs that requires your doctor to get a prior authorization before the prescription is filled. Your doctor must call UnitedHealthcare for approval before you can get any drugs that need a prior authorization.

For non-DDD clients and non-MLTSS members, substance use residential, Methadone, partial care, intensive outpatient and some detox services will be handled through a State designated Interim Managing Entity (IME). They will provide screening, service referrals and continued stay approvals. UnitedHealthcare and IME will coordinate the above substance use services based on your needs. For more information, call Member Services at **1-800-941-4647**, TTY **711**, or the IME at 1-844-276-2777.

Members who are clients of the Division of Developmental Disabilities (DDD) and Community Care Waiver (CCW) can get these services from UnitedHealthcare:

- Psychotherapy
- Psychological counseling and testing, including neuropsychological testing
- Substance use (narcotics, drugs and alcohol) treatment. Call United Behavioral Health (UBH) at 1-800-496-5841 or call Member Services at **1-800-941-4647**, TTY **711** to learn more about these services.

Members who receive MLTSS get their Mental Health/Substance Use Services from UnitedHealthcare. In addition to the Mental Health/Substance Use Services listed in the Benefits Summary, UnitedHealthcare will also coordinate the following services that are not covered by UnitedHealthcare under MLTSS:

- Targeted Case Management (TCM)
- Programs in Assertive Community Treatment (PACT)
- Statewide Clinical Outreach Program for the Elderly (SCOPE)
- Self-help centers
- Supportive housing
- Behavioral health services covered by other sources (TPL)
- Community Support Services (CSS)
- Behavioral Health Home (BHH)

MLTSS members can reach the Behavioral Health Crisis Line by calling **1-888-291-2506** (Option **8**), TTY **711**.

UnitedHealthcare Community Plan covers a number of behavioral health benefits for you. Behavioral health includes both mental health services and substance use disorder treatment services. Some services are covered for you by UnitedHealthcare Community Plan, while some are paid for directly by Medicaid Fee-for-Service (FFS). You will find details in the chart below.

A prior authorization may be needed

Some services that need prior authorization include:

- Hospital admissions
- Home health care services
- Certain outpatient imaging procedures, including MRIs, MRAs, CT scans and PET scans
- Sleep studies
- Medications that are medically necessary but not on the preferred drug list
- Certain dental services — see Dental services table, page 40, for more information

If the prior authorization has expired, a new request for prior authorization will be required.

Behavioral health benefits

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Mental Health					
Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments)	Covered.	Covered by FFS.	Not covered for NJ FamilyCare B, C, and D members.	Not covered for NJ FamilyCare B, C, and D members.	Not covered for NJ FamilyCare B, C, and D members.
Inpatient Psychiatric	Inpatient Psychiatric services are covered by UnitedHealthcare for members in DDD, MLTSS, or FIDE SNP.	Covered. Coverage includes services in a **general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF),** or critical access hospital.	Covered. Coverage includes services in a **general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF),** or critical access hospital.	Covered. Coverage includes services in a **general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF),** or critical access hospital.	Covered. Coverage includes services in a **general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF),** or critical access hospital.
Applied Behavior Analysis (ABA)	Covered with Prior Authorization	Covered with Prior Authorization	Covered with Prior Authorization	Covered with Prior Authorization	Covered with Prior Authorization
Independent Practitioner Network or IPN (Psychiatrist, Psychologist, or APN)	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Developmental Relationship Based Intervention (DRBI) including but not limited to DIR, DIR Floortime and Greenspan approach	Covered.	Covered.	Covered.	Covered.	Covered.
Outpatient Mental Health	Covered.	Covered by FFS. Coverage includes services received in a **General Hospital Outpatient setting, Mental Health Outpatient Clinic/ Hospital** services, and outpatient services received in a **Private Psychiatric Hospital**. Services in these settings are covered for members of all ages.	Covered by FFS. Coverage includes services received in a **General Hospital Outpatient setting, Mental Health Outpatient Clinic/ Hospital** services, and outpatient services received in a **Private Psychiatric Hospital**. Services in these settings are covered for members of all ages.	Covered by FFS. Coverage includes services received in a **General Hospital Outpatient setting, Mental Health Outpatient Clinic/ Hospital** services, and outpatient services received in a **Private Psychiatric Hospital**. Services in these settings are covered for members of all ages.	Covered by FFS. Coverage includes services received in a **General Hospital Outpatient setting, Mental Health Outpatient Clinic/ Hospital** services, and outpatient services received in a **Private Psychiatric Hospital**. Services in these settings are covered for members of all ages.

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Partial Care (Mental Health)	Covered.	Covered by FFS. Limited to 25 hours per week (5 hours per day, 5 days per week). Prior authorization required.	Covered by FFS. Limited to 25 hours per week (5 hours per day, 5 days per week). Prior authorization required.	Covered by FFS. Limited to 25 hours per week (5 hours per day, 5 days per week). Prior authorization required.	Covered by FFS. Limited to 25 hours per week (5 hours per day, 5 days per week). Prior authorization required.
Acute Partial Hospitalization Mental Health/ Psychiatric Partial Hospitalization	Covered.	Covered by FFS. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for Acute Partial Hospitalization.	Covered by FFS. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for Acute Partial Hospitalization.	Covered by FFS. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for Acute Partial Hospitalization.	Covered by FFS. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for Acute Partial Hospitalization.
Psychiatric Emergency Services (PES)/ Affiliated Emergency Services (AES)	Covered by FFS for all members.	Covered by FFS for all members.	Covered by FFS for all members.	Covered by FFS for all members.	Covered by FFS for all members.

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Substance Use Disorder Treatment **The American Society of Addiction Medicine (ASAM) provides guidelines that are used to help determine what kind of substance use disorder (SUD) treatment is appropriate for a person who needs SUD services. Some of the services in this chart show the ASAM level associated with them (which includes "ASAM" followed by a number).**					
Ambulatory Withdrawal Management with Extended On-Site Monitoring/ Ambulatory Detoxification **ASAM 2 – WM**	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
Inpatient Medical Detox/ Medically Managed Inpatient Withdrawal Management (Hospital-based) **ASAM 4 – WM**	Covered for all members.	Covered for all members.	Covered for all members.	Covered for all members.	Covered for all members.
Long Term Residential (LTR) **ASAM 3.5**	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.

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Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Office-Based Addiction Treatment (OBAT)	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.	Covered. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.
Non-Medical Detoxification/ Non-Hospital Based Withdrawal Management **ASAM 3.7 – WM**	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Opioid Treatment Services	Covered.	Covered by FFS. Includes coverage for **Methadone Medication Assisted Treatment (MAT)** and **Non-Methadone Medication Assisted Treatment.** Coverage for **Non-Methadone Medication Assisted Treatment** includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.	Covered by FFS. Includes coverage for **Methadone Medication Assisted Treatment (MAT)** and **Non-Methadone Medication Assisted Treatment.** Coverage for **Non-Methadone Medication Assisted Treatment** includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.	Covered by FFS. Includes coverage for **Methadone Medication Assisted Treatment (MAT)** and **Non-Methadone Medication Assisted Treatment.** Coverage for **Non-Methadone Medication Assisted Treatment** includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.	Covered by FFS. Includes coverage for **Methadone Medication Assisted Treatment (MAT)** and **Non-Methadone Medication Assisted Treatment.** Coverage for **Non-Methadone Medication Assisted Treatment** includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Peer Recovery Support Services (PRSS) provided by Independent Clinics Drug/Alcohol	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
Substance Use Disorder Care Management	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
Substance Use Disorder Outpatient (OP) ASAM 1	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
Substance Use Disorder Partial Care (PC) ASAM 2.5	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.
Substance Use Disorder Short Term Residential (STR) ASAM 3.7	Covered.	Covered by FFS.	Covered by FFS.	Covered by FFS.	Covered by FFS.

Special needs members

Care Management services at UnitedHealthcare are known as the Personal Care Model (PCM). The PCM is for members with complex needs and chronic conditions. When we learn that you have special health needs, either through an Initial Health Screen (IHS) or some other way, we will call you to complete a Comprehensive Needs Assessment (CNA) to tell us what extra services would help you. PCM services include:

- Education including mailings of materials and outreach to members who may have been diagnosed with illnesses such as congestive heart failure, asthma, diabetes, hypertension or depression
- Helping members improve their self-management skills
- Helping members improve their quality of life by working with them to reduce the need for emergency treatment and multiple admissions to the hospital

IDD directory enhancements

- Dental benefits — Refer to page 40 and 88.
- Transportation assistance/ModivCare — Refer to page 29.
- Care Manager — Refer to pages 78 and 86.
- When to contact the dental office/clinic with specific questions and concerns. The parent/caregiver/guardian should share their concerns and provide information concerning the patient. Below are examples of concerns:
  - Accommodations for wheelchair or stretcher bound patient
  - Obtaining information for adaptive equipment and concerns with sensory triggers
  - Desensitization visits
  - Believe that the child/adult may be limited in their ability to tolerate dental care in the office:
  - Questions concerning dental care under sedation in the office
  - Questions concerning dental care in the operating room

  When to contact Member Services:
  - Assistance in identifying a dentist to provide dental treatment to an IDD child/adult. Refer to page 88.
  - Assistance with transportation. Refer to page 29.
- Link to dentists who treat special needs members: **https://www.uhccommunityplan.com/nj/medicaid/familycare/lookup-tools#collapse-179880517**

Once a CNA is completed, an Individual Health Care Plan (IHCP) will be completed to meet your specific health care needs. IHCPs help providers and UnitedHealthcare Care Managers make sure you get all the care you need. The IHCP will be completed within 30 days of completion of the CNA. If you think you need a specialist or need to go to a specialty care center all the time, you can also get a standing referral to a specialist or specialty care center.

If you have questions about care management, call the Special Needs Hotline at 1-877-704-8871, TTY 711. For after-hours crisis situations, call Member Services at **1-800-941-4647**, TTY **711**. Children and adults with special needs who have an existing relationship with an out-of-network provider may continue seeing the doctor if it is determined to be in the best interest of the member.

Children with special health care needs

UnitedHealthcare provides care management to children with special needs and can help coordinate complex health care for children who have serious or chronic physical, developmental, behavioral or emotional conditions. The Care Managers work with the health plan, your children's providers and outside agencies to get the special services and care your children need.

We also have disease management programs to help members with chronic illnesses such as diabetes, asthma, depression, HIV and Sickle Cell by providing advice and ensuring appropriate follow-up visits to providers are done on a timely basis.

Children with special needs also have the Early Periodic Screening, Diagnostic and Treatment (EPSDT) that helps to promote health and prevent any further complications. See page 91 for additional details.

Cultural and linguistic services

UnitedHealthcare wants to help members of all cultures and languages get the care they need. We can arrange translation services over the phone. We can also have an interpreter meet you at your doctor's office if you need help discussing your health with your doctor. We can also provide signers for the deaf and Braille and large print material. If you would like help or information in a language other than English, call Member Services at **1-800-941-4647**, TTY **711**.

MLTSS members

Members who have been assessed for Managed Long-Term Services and Supports (MLTSS) and have met both the financial and clinical eligibility requirements established by the State for MLTSS receive care management and supportive services. The purpose of MLTSS is to enable individuals who are at the nursing home level of care to receive person-centered services in the least restrictive and most coordinated setting.

MLTSS Care Management unit:

1-800-645-9409, TTY 711

UnitedHealthcare Community Plan
P.O. Box 2040
Edison, NJ 08818-2040

You will receive a letter with your Care Manager's name as well as a phone call from your Care Manager. If you need to reach your Care Manager, he or she can be reached through the MLTSS Care Management phone number. If your Care Manager is not available, you can reach a back-up at this number as well.

If you need to reach Care Management after-hours, you can call the MLTSS Care Management number or the NurseLine. You can speak with someone who can review your plan of care and back-up plan, and can authorize services to ensure your health and welfare during times when our offices are closed.

MLTSS Care Management:

1-800-645-9409, TTY 711, 8:00 a.m.–5:00 p.m., Monday–Friday

After-hours, this number forwards to NurseLine:
1-888-433-1904, TTY 711, 24 hours a day, 7 days a week

MLTSS member representative:

1-800-645-9409, TTY 711

Your MLTSS member representative is responsible for:

- Internal representation of the interests of MLTSS members
- Input into planning and delivery of long-term services, supports and evaluation
- Providing education to members, families and providers on issues related to the MLTSS program
- Assisting the members in navigating the system
- Facilitating resolution on any issues, including grievances and appeals

Each MLTSS member has a clear pathway to submit grievances and or appeals to us regarding concerns about choice, quality, eligibility, determination, service provision and outcomes.

For additional information about how to file a grievance or appeal, please refer to page 101 of this book.

Role of the MLTSS Care Manager

Your MLTSS Care Manager is an important part of your care team. He or she helps you with:

- Options counseling and identification of service needs
- Participation and preparation of your plan of care
- Coordination of primary, acute, behavioral and long-term services and supports, including services not covered by UnitedHealthcare
- Coordination of services
- Facilitation and advocacy to help with resolving issues that block or delay access to needed services
- Monitoring and reassessment of services based on changes in your condition
- Assessing the medical need and cost-effectiveness of the services in your plan of care
- Conducting face-to-face visits
- Determining your interest in transitioning to/from an institutional setting to/from the community and the availability of services to facilitate such transition, as appropriate

Community transition services

Services that aid in transitioning from institutional settings to your own home in the community through coverage of non-recurring, one-time transitional expenses.

These are services necessary to help MLTSS members establish a basic household that do not include room and board and includes things like security deposits, household furnishings and other one-time expenses. You should speak with your Care Manager if you are interested in transitioning from an institutional setting back to the community. Your Care Manager can tell you about your right to choose between nursing facility and Home and Community Based Services (HCBS) and help to see if your needs can be safely and cost-effectively met in the community.

Critical incidents

A critical incident means an event during care that may have an adverse effect on the member or others. It may also be an event that affects the operations of a facility. An example is a fall that results in injury.

If you, or someone you are the caregiver of, experience a critical incident, contact your Care Manager through the MLTSS Care Management number: 1-800-645-9409, TTY 711.

A critical incident shall include, but is not limited to, the following incidents:

1. Unexpected death of a member.
2. Media Involvement or the potential for media involvement.
3. Physical abuse (including seclusion and restraints both physical and chemical).
4. Psychological/verbal abuse.
5. Sexual abuse and/or suspected sexual abuse.
6. Fall resulting in the need for medical treatment.
7. Medical emergency resulting in need for medical treatment.
8. Medication error resulting in serious consequences.
9. Psychiatric emergency resulting in the need for medical treatment.
10. Severe injury resulting in the need for medical treatment.
11. Suicide attempt resulting in need for medical attention.
12. Neglect/mistreatment, caregiver (paid or unpaid).
13. Neglect/mistreatment, self.
14. Neglect/mistreatment, other.
15. Exploitation, financial.
16. Exploitation, theft.
17. Exploitation, destruction of property.
18. Exploitation, other.
19. Theft with law enforcement involvement.
20. Failure of member's back-up plan.
21. Elopement/wandering from home or facility.
22. Inaccessible for initial/on-site meeting.
23. Unable to contact.
24. Inappropriate or unprofessional conduct by a provider involving member.
25. Cancellation of utilities.
26. Eviction/loss of home.
27. Facility closure, with direct impact to member's health and welfare.
28. Natural disaster, with direct impact to member's health and welfare.
29. Operational breakdown.
30. Other.

I Choose Home NJ (Money Follows the Person)

I Choose Home NJ is a federal program also known as "Money Follows the Person."

Members may be eligible if all four of the following criteria are met:

1. The member is interested in moving back to the community;
2. The member has lived 90 consecutive days or more in a nursing home or developmental center;
3. The member is eligible for Medicaid (clinical and financial) at least one day prior to leaving the facility; and
4. There is transition to a qualified residence as defined by the Centers for Medicare & Medicaid Services (CMS). If you are eligible, you may be able to move back into the community with supports and services.

To find out more, contact your Care Manager or call I Choose Home NJ at 1-855-466-3005/ 1-855-HOME-005.

Voluntary withdrawal from MLTSS program

You may ask to withdraw from the MLTSS program by calling the MLTSS Care Management number: 1-800-645-9409, TTY 711. We will provide you with the voluntary withdrawal form, and then a copy of the completed form if you choose to withdraw. Prior to withdrawal, we are required to provide face-to-face counseling that covers the results and consequences of withdrawal. If you decline face-to-face counseling, we will offer it by telephone. A representative from the State Office of Community Choice Options (OCCO) will contact you within three business days of receiving your voluntary withdrawal form if your income is above the Federal Poverty Level (FPL). This is to make sure you understand that, if your income is above the FPL, your withdrawal from MLTSS will result in your losing Medicaid coverage. The OCCO representative will confirm with you your wish to withdraw. If you want to continue with MLTSS, the OCCO representative will return the form to your UnitedHealthcare Community Plan care manager and advise your care manager that you want to continue in MLTSS. UnitedHealthcare Community Plan will re-enroll you, if necessary. This voluntary withdrawal does not necessarily mean that you will not be able to obtain NJ FamilyCare benefits.

Personal Preference Program (PPP)

The Personal Preference Program (PPP) is an alternate way for individuals to receive their NJ FamilyCare Personal Care Assistant (PCA) services, giving them more choice.

PCA services are non-emergency, health related tasks through NJ FamilyCare. Tasks include help with activities of daily living (ADLs) and with household duties essential to the patient's health and comfort, such as bathing, dressing, meal preparation, and light housekeeping.

Using a "Cash & Counseling" approach, along with the idea of "consumer direction," PCA services can be accessed under PPP, which allows seniors and people with disabilities who are NJ FamilyCare recipients to direct and manage their own services.

With a monthly cash allowance, participants — or "consumers" — work with a consultant to develop a Cash Management Plan (CMP). This plan helps them decide the services they need and the individuals and/or agencies they can hire to provide those services. Consumers who are cognitively impaired or unable to make their own decisions can choose a representative to make decisions on their behalf.

PPP also includes Fiscal Management (FM) services to help consumers with the financial aspects of the program. The FM handles all payroll responsibilities for participants and acts as a bookkeeping service.

The Personal Preference Program requires greater individual responsibility. But in return, it offers the consumers more control, flexibility and choice over the services they receive.

Why choose the Personal Preference Program?

PPP allows consumers to:

- Choose the services they need and want
- Design a service plan to meet their schedule
- Buy equipment and devices
- Exercise greater control, flexibility and choice over their personal care

Using your cash allowance

You can use your cash allowance to:

- Purchase services from an agency
- Pay a friend or relative to help you
- Buy equipment, appliances, technology or other items that increase your independence, such as a microwave oven, or front loading washing machine that you can reach from your wheelchair

Eligibility

Applicants must be:

- NJ FamilyCare eligible
- Approved for Personal Care Assistant Services (PCA) and need PCA services for at least six months
- Able to self-direct services or choose a representative who can act on his/her behalf

To apply

Members currently receiving PCA services and/or in our MLTSS program can contact their assigned care manager. Those who do not have an assigned care manager may call us at 1-800-645-9409, TTY 711.

Disease and Care Management

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

A team of registered nurses and social workers will work with you, your family, your primary care provider (PCP), other health care providers and community resources to design a plan of care to meet your needs in the most appropriate setting. They can also help you with other things like weight loss, stopping smoking, making appointments with your doctor and reminding you about special tests that you might need.

You or your provider can call us to ask if our care management or disease management programs could help you. If you or your doctor thinks a Care Manager could help you, or if you want more information about our care management or disease management programs, call us at **1-800-941-4647**, TTY **711**.

Wellness programs

UnitedHealthcare has many programs and tools to help keep you and your family healthy, including:

- Classes to help you quit smoking
- Counseling to help you quit smoking
- Pregnancy care and parenting classes
- Nutrition, Diabetes DPP, DSME and MNT classes
- Well-care reminders

Your provider may suggest one of these programs for you. If you want to know more, or to find a program near you, talk to your PCP or call Member Services at **1-800-941-4647**, TTY **711**.

Vision exams

UnitedHealthcare covers eye exams and eyeglasses if they are prescribed for you by an ophthalmologist or an optometrist. You do not need a referral from your PCP to see an in-network provider for a routine eye exam. Choose one from our provider directory or call Member Services at **1-800-941-4647**, TTY **711**, for help. With UnitedHealthcare, you do not need a referral for routine eye care. If you have an eye injury or eye disease, you must work with your PCP, who will help you get the care you need, as well as any referrals.

Routine vision care benefit

Your health plan	Eye exam benefit	Eye wear benefit
FFS and NJ FamilyCare A, ABP and B Children (Under age 21) and Adults	One routine exam every year. No copay. Additional exams are covered if medically needed.	One new pair of glasses* every year or as medically necessary. Replacements for broken or lost glasses are covered, if medically needed.
FFS and NJ FamilyCare A and ABP	One routine exam every year. No copay. Additional exams are covered if medically needed.	One new pair of glasses* every two years (adults 21–59) or every year (adults 60 and over); or as medically necessary. Replacements for broken or lost glasses are covered, if medically needed.
NJ FamilyCare C Children (Under age 21)	One routine exam every year. $5 copay may apply. Additional exams are covered if medically needed.	One new pair of glasses* every year or as medically necessary. Replacements for broken or lost glasses are covered, if medically needed.
NJ FamilyCare D	One routine exam every year. $5 copay may apply. Additional exams are covered if medically needed.	One new pair of glasses* every year or as medically necessary. Replacements for broken or lost glasses are covered, if medically needed.

* Members who are entitled to the benefit may choose glasses from a select group of frames available at participating providers.

Under specific conditions, contact lenses may be provided instead of glasses. Call Member Services to discuss this option at **1-800-941-4647**, TTY **711**.

Replacing lost, stolen or damaged eyewear

For FFS, NJ FamilyCare A, ABP, B, C, and D members, UnitedHealthcare will cover the replacement of lost, stolen or damaged optical appliances up to once every 12 months, with prior authorization and medical necessity.

When your optical appliance prescription changes

UnitedHealthcare may cover the replacement of optical appliances such as eyeglasses more often than the benefit specifies (see grid on the previous page) when there is a prescription change. Your eye doctor should call 1-800-828-1525 for authorization. Costs of medically necessary lenses will be covered in full. Additional vision exams will be covered if medically necessary.

If you have an eye injury or a disease, you may have to see an ophthalmologist. An ophthalmologist is a specialist doctor. You must get a referral from your PCP to see an ophthalmologist. UnitedHealthcare covers all medically necessary care you get from an ophthalmologist.

If you have any questions, call Member Services at **1-800-941-4647**, TTY **711**.

Dental basics

Health plan basics

- We offer comprehensive dental coverage with our in network providers. This includes routine check-ups, fluoride treatments, X-rays and cleanings to help keep teeth and gums strong and healthy. Twice a year for all members, more often with documentation of medical necessity.
- That's not all ... Our plan also offers in-network coverage for restorative care including fillings and extractions and routine oral surgery.
- For a summary of covered dental services, see page 40
- With prior authorization; crowns; partial dentures; full dentures; root canals; and complex oral surgery; as well as other procedures may be covered. Your dental office will submit a prior authorization request to UnitedHealthcare Community Plan on your behalf if they feel you are in need of these procedures.
- Orthodontics require prior authorization and documentation of medical necessity and is age restricted
- Members with special health care needs may need to have their dental care provided in an operating room or ambulatory surgical center. This is based on medical necessity and will require prior authorization by the PCD. Contact your care manager or Member Services at **1-800-941-4647**, TTY **711** for assistance.

Things to know

- You should contact your dentist for all non-life threatening dental emergencies before considering a trip to the emergency room. Your dentist can usually quickly assist you in treating the problem or advise you of treatment options.
- For procedures that may be considered either medical or dental or a combination of both such as surgical procedures for fractured jaws or cyst removal, or for certain types of maxillofacial prosthetics, members may be treated either by dental specialists or medical specialists. The specialists will obtain pre-authorization for medically necessary procedures with the exception that emergency procedures do not require pre-authorization.
- If you use a dentist that is not in UnitedHealthcare's network, or you have dental work that requires a prior authorization and you have not been approved, you may be responsible to pay for the dental treatments
- Contact Member Services for additional information or locating a dentist at **1-800-941-4647**, TTY **711**

Limitations and exclusions

UnitedHealthcare has limitations such as the number of times you can receive a cleaning each calendar year without prior authorization, coverage of treatment provided by an out-of-network dentist, and prior authorization requirements for certain procedures. Some services such as braces require additional approvals from UnitedHealthcare. Additionally, some procedures such as cosmetic whitening are not covered under your dental plan. Contact Member Services for additional information at **1-800-941-4647**, TTY **711**.

Maternity services

UnitedHealthcare Healthy First Steps™

Our Healthy First Steps program makes sure that both mom and baby get good medical care.

We will help you obtain:

- Advice on nutrition, fitness and safety
- Childbirth education
- Doula services
- Breastfeeding education
- Breastfeeding supplies, including breast pumps for nursing moms
- A doctor or nurse midwife
- Medically necessary supplies you may need
- Prenatal and postpartum visits and exams
- Rides to doctor's visits
- Community resources such as Women, Infants and Children (WIC) services
- Tobacco cessation programs for pregnant women — Mom QUIT, NJ Quit Line
- To assist you in finding a dentist for comprehensive dental care (see page 40, Dental services)
- Care after your baby is born
- A pediatrician (child's doctor)

Nutrition is important to a child's development. The Women, Infants and Children (WIC) program provides supplemental nutritious foods to pregnant, breastfeeding and postpartum women, infants and children up to age 5. WIC services include nutrition education and counseling, breastfeeding promotion and support, immunization screening and health care referrals. You will continue to have WIC benefits as long as you're eligible. WIC service agencies have offices throughout New Jersey. Call toll-free 1-866-44-NJ-WIC (1-866-446-5942) (TTY 711) for more information. You can also call Healthy First Steps at 1-800-599-5985, TTY 711.

Call us toll-free at **1-877-813-3417**, TTY **711**, from 8:00 a.m. to 7:00 p.m. Eastern time, Monday through Friday.

It's important to start pregnancy care early. Be sure to go to all of your doctor visits, even if this isn't your first baby.

Having a baby?

When you think you are pregnant, call your local county welfare agency (CWA) office and Member Services at **1-800-941-4647**, TTY **711**. This will help ensure you get all the services available to you.

How to enroll your baby into NJ FamilyCare

When your baby is born, you must enroll him or her in FFS by calling your local county welfare agency or your Medical Assistance Customer Center (MACC). NJ FamilyCare members should call the NJ FamilyCare Program at 1-800-701-0710 or TTY at 1-800-701-0720. You should also call UnitedHealthcare with your child's name, FFS ID number and Social Security number when issued. For help, please call Member Services at **1-800-941-4647**, TTY **711**, or NJ FamilyCare at 1-800-701-0710 or TTY at 1-800-701-0720.

Pediatric care/EPSDT services

During the first few years of your baby's life, it will be necessary to take your child to the doctor every few months for checkups. These checkups include immunizations (shots) that protect your child from diseases. Ask your child's doctor about the shots your child may need and assistance scheduling regular EPSDT well-visit checkups.

Nutrition is important to a child's development. The Women, Infants and Children (WIC) program provides supplemental nutritious foods to pregnant, breastfeeding and postpartum women, infants and children up to age 5. WIC services include nutrition education and counseling, breastfeeding promotion and support, immunization screening and health care referrals. You will continue to have WIC benefits as long as you're eligible. WIC service agencies have offices throughout New Jersey. Call toll-free 1-866-44-NJ-WIC (1-866-446-5942) (TTY 711) for more information. You can also call Healthy First Steps at 1-800-599-5985, TTY 711.

EPSDT program

Your child needs to see a doctor for regular checkups, even when he or she feels healthy. If your child starts to have a health problem, you can call a doctor who already knows your child.

Benefits

With UnitedHealthcare, your child is covered for all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services from your child's PCP. Bright Futures/American Academy of Pediatrics (AAP) shall be utilized as a model of pediatric standard of care and best practices clinical practice guidelines for EPSDT screening. The EPSDT program helps UnitedHealthcare members make sure their children stay healthy and checks to make sure they are growing normally. EPSDT services include:

- Immunizations (shots).
  Appropriate immunizations according to age and health history.
- Physical exams.
  A comprehensive Health and Developmental history, including an assessment of both physical and mental health development. A comprehensive unclothed physical examination.
- Vision and hearing tests
- Nutrition (eating habits)
- Lab tests.
  Hemoglobin or Hematocrit, Urinalysis, Tuberculin skin test (Mantoux). Additional laboratory tests which may be appropriate and medically indicated.
- First dental exam by age 1 or when the first tooth comes in
- Dental checkups twice a year as well as all needed dental treatment
- Please refer to the UHCCP website **UHCCommunityPlan.com** for a listing of providers in the New Jersey Smiles Program or call Member Services at **1-800-941-4647**, TTY **711**
- Referrals for specialty care.
  Referral for further diagnosis and treatment or follow-up of all correctable abnormalities, uncovered or suspected. Referral to the Special Supplemental Food Program for Women, Infants and Children (WIC) for children under five years of age and for pregnant or lactating women.
- Lead screening.
  Lead screenings through blood lead level testing must be performed at 12 and 24 months of age or at 27-72 months of age if never tested. Lead screening using blood lead level determinations between 6 and 12 months, at 2 years of age and annually up to 6 years of age.
- Autism spectrum disorder.
  Applied behavioral analysis (ABA) screening and treatment and Developmental Relationship Based Intervention (DRBI).
- Other services, referrals, or medically necessary therapies. Some of these services need to be approved by UnitedHealthcare before your child receives them. Your child's PCP will call UnitedHealthcare to ask for the authorization and, if approved, will make the arrangements.

See benefits package page 46 as well as EPSDT on page 51, this section includes immunization summary.

Many of these services are already part of your child's EPSDT well-child visit. You should take your child for a well-child visit immediately after birth within 3–5 days, 1 month, 18 months and 30 months and then annually starting at 3 years through 20 years.

Note: Treatment services for NJ FamilyCare B, C, and D are limited to those that are provided by UnitedHealthcare or covered under the FFS program. These services include EPSDT early and periodic screening, preventive and diagnostic medical services and dental, vision, hearing and lead screenings. It includes treatment services identified during exams available through UnitedHealthcare or specified services under the FFS program.

Preventive health care

All required immunizations determined by age

Visiting the doctor regularly will help you stay healthier. There are specific types of tests, screenings or vaccines you should have, based on your age:

- Children from birth through age 20 should have annual EPSDT exams, including lead screening. Lead screening using blood lead level determinations must be done for every Medicaid-eligible and NJ FamilyCare child:
  - Between nine (9) months and eighteen (18) months, preferably at twelve (12) months of age
  - At 18–26 months, preferably at twenty-four (24) months of age
  - Test any child between twenty-seven (27) to seventy-two (72) months of age not previously tested
- Flu or pneumonia vaccine when required
- Breast, colorectal or prostate cancer screenings
- Twice yearly dental checkups and cleanings are covered and available to all members. Be sure to complete all recommended dental treatment.

Ask your doctor if you think you should have these services.

Refer to the benefits grid for specific information regarding cancer screening.

Other plan details

Finding a network provider, pharmacy, or a lab

To find a network provider, pharmacy, or lab services close to you:

Visit **myuhc.com/CommunityPlan** for the most up-do-date information.
Click on "Find a Provider."

Call Member Services at **1-800-941-4647**, TTY **711**. We can look up network providers for you. Or, if you'd like, we can send you a Provider Directory in the mail.

Provider Directory

You have a directory of providers available to you in your area. The directory lists names, addresses, phone numbers, professional qualifications, specialty and board certification of our in-network providers.

Provider information changes often. Visit our website for the most up-to-date listing at **myuhc.com/CommunityPlan**. You can view or print the provider directory from the website, or click on "Find a Provider" to use our online searchable directory. If you are looking for a listing for dentists who treat children under age 6, click on "Dentist Lookup" to use our online searchable directory.

If you would like a printed copy of our directory, please call Member Services at **1-800-941-4647**, TTY **711**, and we will mail one to you.

New technology assessment

Some medical practices and treatments are not yet proven to be effective. New practices, treatments, tests and technologies are reviewed nationally by UnitedHealthcare to make decisions about new medical practices and treatments and what conditions they can be used to treat. This information is reviewed by a committee of UnitedHealthcare doctors, nurses, pharmacists and guest experts who make the final decision about coverage. If you would like more information about how we make decisions about new medical practices and treatments, call us at **1-800-941-4647**, TTY **711**.

Interpreter services and language assistance

Many of our Member Services employees speak more than one language. If you can't connect with one who speaks your language, you can use an interpreter to help you speak with Member Services.

Many of our network providers also speak more than one language. If you see one who doesn't speak your language, you can use our interpreter or sign language services to help you during your appointment. Arrange for your translation services at least 72 hours before your appointment. Sign language services require two weeks' notice.

You can also have any printed materials we send you either sent in a different language or translated for you. To arrange for interpreter, translation services or audio format, call Member Services at **1-800-941-4647**, TTY **711**.

Assurance Wireless Lifeline Services

As a member, or as the guardian of a UnitedHealthcare member, you may qualify for Assurance Wireless Lifeline Services, a mobile phone and service plan, at no cost. As an Assurance Wireless customer, you can easily access:

- Health-related information from UnitedHealthcare
- Benefit and program reminders via text for you and your family
- UnitedHealthcare Member Services

Already have Lifeline? You can switch from your current service provider.

Choose the Lifeline service that's right for you.

Visit **AssuranceWireless.com/partner/buhc** to apply or learn more about Assurance Wireless Lifeline plans.

Updating your information

To ensure that the personal information we have for you is correct, please tell us if any of the following changes:

- Marital status
- Address
- Member name
- Phone number
- You become pregnant
- Family size (new baby, death, etc.)
- Other health insurance

Please call Member Services at **1-800-941-4647**, TTY **711**, if any of this information changes. UnitedHealthcare needs up-to-date records to tell you about new programs, to send you reminders about healthy checkups, and to mail you member newsletters, ID cards and other important information. You should also tell NJ FamilyCare if you have any changes. Their telephone number is 1-800-701-0710 (TTY 1-800-701-0720). They need updated address information every time you move.

Other insurance

If you have any other insurance, call Member Services and let us know.

- If you are a member, your other health insurance will have to pay your health care bills first
- When you get care, show all health insurance ID cards (for UnitedHealthcare and your other health insurance plans)

Fraud, waste and abuse

UnitedHealthcare wants you to report any provider (for example a doctor, dentist, therapist, hospital or medical equipment supplier) that you suspect of fraud, waste or abuse for services provided to you or anyone with UnitedHealthcare coverage. Please call Member Services at **1-800-941-4647**, TTY **711**. Some common forms of fraud, waste and abuse are:

- Billing or charging you for covered services, except any copays listed on your member ID card
- Billing or charging UnitedHealthcare for services you never received
- Offering you gifts or money to give you treatment or services
- Offering you free services, equipment or supplies in exchange for your member ID number
- Giving you treatment or services that you don't need

You do not have to give your name when you report someone. If you do, the provider will not be told that you called. If you don't speak English, an interpreter will be made available. You can also report suspected fraud, waste or abuse to the State of New Jersey by calling 1-888-937-2835.

Your opinion matters

Do you have any ideas about how to make UnitedHealthcare better? There are many ways you can tell us what you think.

- Call Member Services at **1-800-941-4647**, TTY **711**
- Write to us at:

  UnitedHealthcare Community Plan
  P.O. Box 2040
  Edison, NJ 08818-2040

Member Advisory Committee

We also have a Member Advisory Committee that meets every three months. If you'd like to join us, call Member Services.

Utilization management

UnitedHealthcare Community Plan does not want you to get too little care or care you don't really need. We also have to make sure that the care you get is a covered benefit. Decisions about care are based only on appropriateness of care and existing coverage. We use utilization management (UM) to make sure you are getting the right care at the right time and in the right place. Only doctors, dentists and pharmacists perform UM. We do not reward anyone for saying no to needed care. We do not offer incentives to our re-viewers for making decisions that result in not enough care. If you have questions about UM, you can talk to our Medicaid Case Management staff. Staff are available 8:00 a.m. to 6:00 p.m. at **1-800-941-4647**, TTY **711**.

Utilization management appeal process:

Service denial/limitation/reduction/termination based on medical necessity.

You and your provider should receive a notification letter within 2 business days of any health plan decision to deny, reduce, or terminate a service or benefit. If you disagree with the plan's decision, you (or your provider, with your written permission) can challenge it by requesting an appeal. See the summary below for the timeframes to request an appeal.

Utilization management appeal process

Stages	Timeframe for member/provider to request appeal	Timeframe for member/provider to request appeal with continuation of benefits for existing services	Timeframe for appeal determination to be reached	FamilyCare Plan type
Internal Appeal The **Internal Appeal** is the first level of appeal, administered by the health plan. This level of appeal is a formal, internal review by health care professionals selected by the plan who have expertise appropriate to the case in question, and who were not involved in the original determination.	60 calendar days from date on initial notification/denial letter	• On or before the last day of the current authorization; **or** • Within ten calendar days of the date on the notification letter, **whichever is later**.	30 calendar days or less from health plan's receipt of the appeal request	A/ABP B C D

Stages	Timeframe for member/provider to request appeal	Timeframe for member/provider to request appeal with continuation of benefits for existing services	Timeframe for appeal determination to be reached	FamilyCare Plan type
External/IURO Appeal The External/IURO appeal is an external appeal conducted by an **I**ndependent **U**tilization **R**eview **O**rganization (IURO).	60 calendar days from date on Internal Appeal notification letter	• On or before the last day of the current authorization; **or** • Within ten calendar days of the date on the Internal Appeal notification letter, **whichever is later**.	45 calendar days or less from IURO's decision to review the case	A/ABP B C D
Medicaid Fair Hearing	120 calendar days from date on Internal Appeal notification letter	**Whichever is the latest of the following:** • On or before the last day of the current authorization; **or** • Within ten calendar days of the date on the Internal Appeal notification letter; **or** • Within ten calendar days of the date on the External/IURO appeal decision notification letter.	A final decision will be reached within 90 calendar days of the Fair Hearing request	A/ABP **only**

Appeals and grievances

Initial adverse determination

If UnitedHealthcare decides to deny your initial request for a service, or to reduce or stop an ongoing service that you have been receiving for a while, this decision is also known as an **adverse determination**. We will tell you and your provider about this decision as soon as we can, often by phone. You will receive a written letter explaining our decision within two business days.

If you disagree with the plan's decision, you, your provider (with your written permission) can challenge the decision by requesting an **appeal**. You or your provider can request an appeal either orally (by phone) or in writing. To request an appeal orally, you can call the plan at **1-800-941-4647**, TTY **711**, 24 hours a day, 7 days a week. Written appeal requests should be mailed to the following address:

Grievances and Appeals
UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131

You have **60 calendar days** from the date on the initial adverse determination letter to request an appeal.

Internal Appeal

The first stage of the appeal process is a formal internal appeal to the plan (called an Internal Appeal). Your case will be reviewed by a doctor or another health care professional, selected by UnitedHealthcare who has expertise in the area of medical knowledge appropriate for your case. We will be careful to choose someone who was not involved in making the original decision about your care. We must make a decision about your appeal within 30 calendar days (or sooner, if your medical condition makes it necessary).

If your appeal is denied (not decided in your favor), you will receive a written letter from us explaining our decision. The letter will also include information about your right to an External Independent Utilization Review Organization (IURO) Appeal, and/or your right to a Medicaid State Fair Hearing, and how to request these types of further appeal. You will also find more details on those options later in this section of the handbook.

Expedited (fast) Appeals

You have the option of requesting an expedited (fast) appeal if you feel that your health will suffer if we take the standard amount of time (up to 30 calendar days) to make a decision about your appeal. Also, If your provider informs us that taking up to 30 calendar days to reach a decision could seriously jeopardize your life or health, or your ability to fully recover from your current condition attain, we must make a decision about your appeal within 72 hours.

External (IURO) Appeal

If your Internal Appeal is not decided in your favor, you (or your provider acting on your behalf with your written consent) can request an External (IURO) Appeal by completing the **External Appeal Application** form. A copy of the External Appeal Application form will be sent to you with the letter that tells you about the outcome of your Internal Appeal. You or your provider must mail the completed form to the following address **within 60 calendar days** of the date on your Internal Appeal outcome letter:

Maximus Federal – NJ IHCAP
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

You may also fax the completed form to 585-425-5296, or send it by email to **stateappealseast@maximus.com**.

If a copy of the External Appeal Application is not included with your Internal Appeal outcome letter, please call Member Services at **1-800-941-4647**, TTY **711** to request a copy.

External (IURO) Appeals are not conducted by the plan. These appeals are reviewed by an Independent Utilization Review Organization (IURO), which is an impartial third-party review organization that is not directly affiliated with either the plan or the State of New Jersey. The IURO will assign your case to an independent physician, who will review your case and make a decision. If the IURO decides to accept your case for review, they will make their decision within 45 calendar days (or sooner, if your medical condition makes it necessary).

You can also request an expedited, or fast, External (IURO) Appeal, just as you can with Internal Appeals. To request an expedited appeal, you or your provider should fax a completed copy of the External Appeal Application form to Maximus Federal at 585-425-5296, and ask for an expedited appeal on the form in **Section V, Summary of Appeal**. In the case of an expedited External (IURO) Appeal, the IURO must make a decision about your appeal **within 48 hours**.

If you have questions about the External (IURO) Appeal process, or if you would like to request assistance with your application, you can also call the New Jersey Department of Banking and Insurance (DOBI) at 1-888-393-1062 or 609-777-9470.

The External (IURO) Appeal is optional. You don't need to request an External (IURO) appeal before you request a Medicaid State Fair Hearing. Once your Internal Appeal is finished, you have the following options for requesting an External (IURO) Appeal **and/or** a Medicaid State Fair Hearing:

- You can request an External (IURO) Appeal, wait for the IURO's decision, and **then** request a Medicaid State Fair Hearing, if the IURO did not decide in your favor
- You can request an External (IURO) Appeal **and** a Medicaid State Fair Hearing **at the same time** (just keep in mind that you make these two requests to different government agencies)
- You can request a Medicaid State Fair Hearing **without** requesting an External (IURO) Appeal

Also, please note: Medicaid Fair Hearings are only available to NJ FamilyCare Plan A and ABP members.

Medicaid State Fair Hearing

You have the option to request a Medicaid State Fair Hearing after your Internal Appeal is finished (and UnitedHealthcare has made a decision). Medicaid State Fair Hearings are administered by staff from the New Jersey Office of Administrative Law. You have up to **120 calendar days** from the date on your **Internal Appeal outcome letter** to request a Medicaid State Fair Hearing. You can request a Medicaid State Fair Hearing by writing to the following address:

Fair Hearing Section
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

If you make an expedited (fast) Medicaid State Fair Hearing request, and you meet all of the requirements for an expedited appeal, a decision will be made within 72 hours of the day the state agency received your Medicaid Fair Hearing request.

Please note: The deadline for requesting a Medicaid State Fair Hearing is always 120 days from the date on the letter explaining the outcome of your Internal Appeal. This is true even if you request an External (IURO) Appeal in the meantime. The 120 day deadline to ask for a Medicaid State Fair Hearing always starts from the outcome of your Internal Appeal, **not** your External (IURO) Appeal.

Continuation of benefits

If you are asking for an appeal because the plan is stopping or reducing a service or a course of treatment that you have already been receiving, you can have your services/benefits continue during the appeal process. UnitedHealthcare will automatically continue to provide the service(s) while your appeal is pending, as long as all of the following requirements are met:

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- You (or your provider, acting on your behalf with your written consent) file(s) the appeal within **10 calendar days** of the date on the initial adverse determination letter, or on or before the final day of the original authorization, **whichever is later**.

Your services will **not** continue automatically during a Medicaid State Fair Hearing. If you want your services to continue during a Medicaid State Fair Hearing, you must request that **in writing** when you request a Fair Hearing, and you must make that request within:

- **10 calendar days** of the date on the Internal Appeal outcome letter; **or** within
- **10 calendar days** of the date on the letter informing you of the outcome of your External (IURO) Appeal, if you requested one; **or**
- On or before the final day of the original authorization, **whichever is later**.

Please note: If you ask to have your services continue during a Medicaid State Fair Hearing and the final decision is not in your favor, you may be required to pay for the cost of your continued services.

If you have any questions about the appeal process, you can contact Member Services at **1-800-941-4647**, TTY **711**, 24 hours a day, 7 days a week.

Grievances

If you have a problem

A grievance is an expression of dissatisfaction about any matter, a complaint, or a protest by a member as to the conduct by UnitedHealthcare Community Plan or any in-network provider. It could also be a failure to act by UnitedHealthcare Community Plan or any in-network provider on behalf of a member, or any other matter in which a member feels unfairly treated by UnitedHealthcare Community Plan communicated verbally or in writing. You, your provider or representative with your written consent, have the right to file a grievance at any time. The easiest way to get answers to your questions or to file a grievance is to call Member Services at **1-800-941-4647**, TTY **711**. You can also write to:

Grievances and Appeals
UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131

If you call or write to tell us about a grievance, we will write back to you within 5 business days to say we receive your grievance. We will look into your grievance and work hard to answer it within 30 calendar days. We'll send you a letter with our answer written in your primary language informing you of the resolution.

Neither UnitedHealthcare Community Plan, nor any of its providers, will ever penalize you or your provider for filing a grievance or appeal, or a request for a Fair Hearing. You may call Member Services at **1-800-941-4647**, TTY **711**, if you have any questions about your rights.

Advance Directives and living wills

All adult UnitedHealthcare members have the right to give advance written instructions about medical care in case they become incapacitated per § 42 CFR 489.100. Advance directives are written instructions that you make ahead of time in case you become too ill to make those decisions for yourself. They are sometimes called "living wills" or a "medical power of attorney." You can state what kind of treatment you want or do not want — such as being fed with tubes if you are unable to eat or being on a respirator (breathing machine) — and you can name a person who can make those decisions for you per § 42 CFR 422.128. If there is a change in NJ State Law, the information must reflect changes as soon as possible, but no later than 90 days after the effective date of the State law.

It's a good idea to make sure your PCP and any specialists you see know your wishes before you're hospitalized. If you want to make a living will or advance directive, please call Member Services at **1-800-941-4647**, TTY **711**. You should also speak with your Care Manager about a living will or advance directive. You may change your decisions about your living will or advance directive at any time.

Member rights and responsibilities

Uphold member "Bill of Rights"

As a UnitedHealthcare member, you have certain rights and responsibilities when you enroll. These rights also apply to minor members with disabilities. It is important that you fully understand both your rights and your responsibilities. The following statement of rights and responsibilities is presented here for your information. The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the State agency treat the enrollee.

Members have the right to:

1. Be treated with respect, dignity and privacy by UnitedHealthcare and its providers.
2. Be told about any illness you have.
3. Be told of any care or treatment that your PCP feels should be done before anything is done, even if UnitedHealthcare does not cover it. This includes the right to get accurate, easy-to-understand information to help you make good choices about your treatment.
4. Refuse treatment as far as the law allows and to know what the outcome may be.
5. Expect your doctors to keep your records and anything you say private. No information will be released to anyone without your consent, unless required by law.
6. Request a current directory of providers in the UnitedHealthcare network to choose your own PCP.
7. Get needed medical services within a reasonable length of time.
8. If you have a baby, you have the right to stay in the hospital for at least 48 hours after the delivery if it is a normal vaginal delivery. If you have a Cesarean section, you may stay in the hospital at least 96 hours after your baby is born.
9. File a grievance or an appeal to UnitedHealthcare and to get a reply in a timely manner.
10. To receive information about UnitedHealthcare, its services, its practitioners and providers, member rights and responsibilities, and to be informed of UnitedHealthcare rules and any changes that are made.

11. Make suggestions regarding UnitedHealthcare policies and procedures, including your rights and responsibilities.
12. Talk about your medical records with your PCP and to get a complete copy of those records.
13. Be informed of all FFS benefits you are eligible for and of all medical services available to you by UnitedHealthcare.
14. Have an authorized representative of your choice to make medical determinations for you.
15. Ask for a second opinion about any medical care that your PCP advises you to have.
16. Know how UnitedHealthcare decides whether a service is covered and/or is medically necessary.
17. A translator if you need one when you talk to us or one of our providers.
18. Participate in all decisions about your health care and the development of any plan of care designed for you.
19. Speak to providers in private and to have your medical records kept private.
20. Be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect.
21. Be free of hazardous procedures.
22. Be free from balance billing.
23. Have services provided that promote a meaningful quality of life and independence for yourself, including living in your own home or another community setting as long as it is medically and socially feasible, and the right to the preservation and assistance of your natural support system.
24. Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, gender identity, marital status, or disability.
25. Obtain information about our providers that includes the provider's education, residency completed, board certification and recertification. To get this information, call our Member Services Department at **1-800-941-4647**, TTY **711**.

Additional rights for MLTSS members:

1. To request and receive information on choice of services available.
2. Have access to and choice of qualified service providers.
3. Be informed of your rights prior to receiving chosen and approved services.
4. Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability.
5. Have access to appropriate services that support your health and welfare.
6. To assume risk after being fully informed and able to understand the risks and consequences of the decisions made.

7. To make decisions concerning your care needs.
8. Participate in the development of and changes to your Plan of Care.
9. Request changes in services at any time, including add, increase, decrease or discontinue.
10. Request and receive from your Care Manager a list of names and duties of any person(s) assigned to provide services to you under your Plan of Care.
11. Receive support and direction from your Care Manager to resolve concerns about your care needs and/or grievances about services or providers.
12. Be informed of and receive in writing facility specific resident rights upon admission to an institutional or residential setting.
13. Be informed of all the covered/required services you are entitled to, required by and/or offered by the institutional or residential setting, and any charges not covered by the managed care plan while in the facility.
14. Not to be transferred or discharged out of a facility except for medical necessity; to protect your physical welfare and safety or the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice of non-payment to the facility from available income as reported on the statement of available income for FFS payment.
15. Have your health plan protect and promote your ability to exercise all rights identified in this document.
16. Have all rights and responsibilities outlined here forwarded to your authorized representative or court-appointed legal guardian.

Personal Health Information (PHI)

UnitedHealthcare is required by law to protect the privacy of your health coverage. We are obligated to keep your information secure and confidential. We do not sell information about you and do not share your PHI except to communicate with our health care partners. Our employees protect your PHI whether it is provided orally, in writing or electronically. You have the right to request access to inspect, copy and amend your PHI. You can also request restrictions on certain use and disclosures of your PHI.

If you would like to exercise these rights or need more information, please call Member Services at **1-800-941-4647**, TTY **711**, or go to the following site: **http://www.UHCCommunityPlan.com/privacy-policy.html**.

New Jersey HMO Consumer Bill of Rights

In addition to the rights you have as a member of UnitedHealthcare, you also have these rights as a member of a health plan in New Jersey:

1. To obtain a current directory of doctors in the UnitedHealthcare network.
2. To have a choice of specialists following a referral.
3. To be referred to specialists who are experienced in treating disabilities if you have a chronic disability.
4. To have access to a PCP or an attending physician 24 hours a day, 365 days a year.
5. To call 911 in a potentially life-threatening situation without prior authorization from UnitedHealthcare.
6. To have UnitedHealthcare pay for your medical screening exam in the emergency room to determine if an emergency medical condition exists.
7. To receive up to four months (or one year depending on your condition) of continued coverage — if it is medically necessary — from a doctor who terminated from UnitedHealthcare.
8. To have a doctor make the decision to deny or limit your coverage.
9. To no "gag rules." Your doctors are free to discuss all medical treatment options, even if they are not covered services.
10. To know how UnitedHealthcare pays providers so you know if there are any financial incentives (rewards) or disincentives (no rewards) when he or she makes medical decisions.
11. To appeal a decision to deny or limit coverage, first with UnitedHealthcare and then through an independent organization (with a filing fee).
12. To know that you or your doctor cannot be penalized for filing a grievance or appeal.
13. To be notified of any changes in benefits, services, or our provider network.
14. Not to be charged any doctors' fees above/beyond what UnitedHealthcare or FFS pays the provider.
15. To receive an explanation, in terms you can understand, of your complete medical condition from any of your providers.
16. To choose a PCP within the limits of the covered benefits.
17. To be provided with information about UnitedHealthcare's policies and procedures, rights and responsibilities, products, services, providers and appeal procedures.
18. To file a grievance or an appeal to us or the State Department of Banking and Insurance or the Division of Medical Assistance and Health Services. You have the right to receive an answer to those grievances within a reasonable period of time. Those who have NJ FamilyCare A and NJ FamilyCare ABP have a right to the Medicaid Fair Hearing process.

Your responsibilities

1. To supply information (to the extent possible) that the Health Plan and its practitioners and providers need in order to provide care.
2. To follow plans and instructions for care that you have agreed to with their practitioners.
3. To understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Additional responsibilities for MLTSS members

1. Provide all health and treatment related information, including but not limited to, medication, circumstances, living arrangements, informal and formal supports to the Plan's Care Manager in order to identify care needs and develop your plan of care;
2. Understand your health care needs and work with your Care Manager to develop or change goals and services;
3. Work with your Care Manager to develop and/or revise your Plan of Care to facilitate timely authorization and implementation of services;
4. Ask questions when additional understanding is needed;
5. Understand the risks associated with your decisions about care;
6. Report any significant changes in your health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager;
7. Notify your Care Manager should any problem occur or if you are dissatisfied with the services being provided;
8. Follow your health plan's rules and/or those rules of institutional or residential settings; and
9. Pay your monthly payment liability to your assisted living or nursing facility, if you have one.

* Failure to pay your payment liability can result in termination from the health plan or your service provider choosing to discontinue providing living arrangements and services.

NJ FamilyCare

If you are enrolled in NJ FamilyCare A or NJ FamilyCare ABP (with some exceptions), the benefits and the UnitedHealthcare policies that affect you are exactly the same as those described in this handbook.

If you are enrolled in NJ FamilyCare B or C or D, all the UnitedHealthcare benefits described in this handbook are covered, but you cannot ask for a Medicaid fair hearing if you have a grievance against UnitedHealthcare. You can file grievances and appeals by calling Member Services at **1-800-941-4647**, TTY **711**.

Members of NJ FamilyCare C and D must pay the following fees:

NJ FamilyCare C

1. Copays between $1 and $10. Alaskan Natives and Native Americans under age 19 do not have a copay.
2. Total annual copays will not be more than 5% of your family's yearly income. It's your responsibility to keep track of your total copays for the year. Call the Health Benefits Coordinator at 1-800-701-0710 (TTY 1-800-701-0720) once you reach your yearly limit.

NJ FamilyCare D

1. Copayments, not to exceed $35 per service. Alaskan Natives and Native Americans under the age of 19 do not have a copay.
2. Total annual copays will not be more than 5% of your family's yearly income. It's your responsibility to keep track of your total payments for the year. Call the Health Benefits Coordinator at 1-800-701-0710 (TTY 1-800-701-0720) once you reach your yearly limit.

If you have questions about these NJ FamilyCare rules, please call Member Services toll-free at **1-800-941-4647**, TTY **711**.

(Subject to change)
NJ FamilyCare C (Personal contributions to care)
Note: Copayments are required only if indicated on your ID card.

Outpatient hospital visits (except for preventive services)	$5
Emergency services in a hospital: Emergency Room	$10
Physician visits (except for well-child visits, lead screening and treatment, age-appropriate immunizations, prenatal care, and pap smears, when appropriate)	$5
Independent clinic visits (including Federally Qualified Health Centers; except for preventive services)	$5
Podiatrist visits (foot doctor) (no routine care)	$5
Optometrist visits	$5
Nurse midwife visits (except for prenatal care visits)	$5
Dentist visits (except for diagnostic and preventive services)	$5
Chiropractor visits	$5
Nurse practitioner visits (except for preventive care services)	$5
Generic prescription drugs	$1
Brand name prescription drugs	$5

(Subject to change)
NJ FamilyCare D copayments
Note: Copayments are required only if indicated on your ID card.

Primary care/specialist physician office visits during normal office hours (except for well-child care, lead screening and treatment, age-appropriate immunizations, prenatal care)	$5
Primary care/specialist physician office visits during non-office hours or home visit	$5
Dentist visits (except for diagnostic and preventive care services)	$5
Initial maternity visit (to doctor or nurse midwife) during normal office hours	$5
Initial maternity visit (to doctor or nurse midwife) during non-office hours	$5
Nurse practitioner's visit (except preventive services)	$5
Nurse practitioner's visit during non-office hours (except for preventive services)	$5
Optometrist visits (except for newborns covered under fee-for-service)	$5
Podiatrist visits (foot doctor) (no routine care)	$5
Psychologist services	$5
Laboratory and X-ray services that are not part of an office visit	$5

Emergency room services (except if admitted to the hospital or if referred to the emergency room by your PCP for services that should have been given in the doctor's office)	$35
Outpatient hospital clinic visits (except for preventive services)	$5
Prescription drugs	$5
Prescription drugs — more than a 34-day supply	$5
Hospital outpatient mental health services	$5
Outpatient substance use services for detoxification	$5
Outpatient rehabilitation visits	$5

There are no copayments for the following services:

- Emergency ambulance services
- All maternity visits after the first visit
- Outpatient surgery
- Home health services
- Hospice services
- Inpatient hospital services
- Inpatient substance use detoxification services
- Inpatient mental health services
- Diagnostic and preventive dental services

Exclusions

The following services are not covered:

- Services that are deemed not medically necessary
- Cosmetic surgery (including cosmetic dentistry), except when medically necessary and with prior approval
- Experimental organ transplants and investigational services
- Infertility diagnosis and treatment services
- Rest cures, personal comfort, convenience items and custodial care

- Respite care (except for MLTSS members)
- Services involving the use, purchase, rental or construction of equipment in facilities that have not been approved by applicable laws and regulations of the State of New Jersey
- All claims arising directly from services provided by or in institutions owned or operated by the federal government such as Veterans Administration hospitals
- Services provided to all persons without charge. Services and items provided without charge through programs of other public or voluntary agencies shall be utilized to the fullest extent possible.
- Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military
- Services provided outside the United States and territories
- Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the FFS beneficiary claims or receives benefits thereunder and whether or not any recovery is obtained from a third-party for resulting damages
- That part of any benefit which is covered or payable under any health, accident, long-term care or other insurance policy (including any benefits payable under the New Jersey no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similarly third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund
- Any service or items furnished for which the provider does not normally charge
- Voluntary Services or informal support furnished by a relative, friend, neighbor, or member of the FFS beneficiary's household except if provided through participant direction
- Services billed for which corresponding health care records do not adequately and legibly reflect the requirements of the procedure code utilized by the bill provider
- Services or items reimbursed based upon submission of a cost study when there are no acceptable records or other evidence to substantiate either the costs allegedly incurred or beneficiary income available to offset those costs. In the absence of financial records, a provider may substantiate costs or available income by means of other evidence acceptable to the Division.

If you get a bill

For most members, your benefits will not cost you anything. You should not be charged for receiving any covered benefits unless you are enrolled in Plan C or D and have a copay. Refer to the attached newsletter regarding Balance Billing for NJ Family Care members.

The federal Medicaid and Medicare Act prohibits participating providers from billing program participants for any eligible services. Refer to the following laws:

- 42 C.F.R. § 447.20 — The provider furnishing the service to the individual may not seek to collect from the individual any payment for eligible services.
- 42 C.F.R. § 447.15 — Health care providers participating in state Medicaid and Medicare programs agree to accept Medicaid and Medicare payments as payment in full.
- 42 U.S.C. § 1396a (a) (25) (c) — State plans may not allow health care providers to seek payment for eligible services from a beneficiary or the beneficiary's relatives.

With the exceptions noted in this handbook (such as emergency care, out-of-network family planning care, etc.), you should get all your health care from UnitedHealthcare providers unless you have other primary health insurance such as Medicare or other health insurance. If you go to a provider outside our network for a service that an in-network doctor could provide (except in an emergency) without first getting our permission, neither UnitedHealthcare nor FFS nor NJ FamilyCare will pay for that care.

You may be asked to pay for services that are not covered by FFS or UnitedHealthcare. You cannot be charged for any such service unless you agree to pay before you get the care. If you are asked to pay for such a service and you are not sure whether it is covered, call Member Services at **1-800-941-4647**, TTY **711**.

If you get a medical bill, call Member Services at **1-800-941-4647**, TTY **711**. You will be asked some questions, so please have your member number, the date of the service, the provider and why you think you received a bill when you call. UnitedHealthcare will fix this problem for you.

Additional resources

You can get more information in the following websites:

- Medicaid Newsletter:
  https://www.njmmis.com/downloadDocuments/23-15
- Balance Billing Newsletter:
  https://www.nj.gov/humanservices/dmahs/home/Medicaid_TPL_Coverage_Guide.pdf

Other insurance

You must let us know if you have other health insurance. This will let you get the maximum benefits under each plan. Your main health insurance will pay first. UnitedHealthcare will pay last. Your main health insurance will provide you with an explanation of benefits (EOB). It tells you exactly how each claim was covered by your main health insurance. You should receive one EOB for each medical claim.

If you are enrolled in Medicare and UnitedHealthcare FFS is secondary, the secondary claim must be submitted with a claim form with the Medicare explanation of benefits. Your provider is responsible for submitting the claim to UnitedHealthcare.

Some individuals in the Aged, Blind and Disabled (ABD) category, including DDD clients, may be enrolled in UnitedHealthcare. These members are not responsible for payment if the other payer denies the services or payment of services. UnitedHealthcare will pay for these services according to the terms of its contractual agreement with the provider. We recommend you show all health insurance cards any time you visit a doctor, hospital, pharmacy, lab or other service provider.

For members who have auto insurance, you do not have the option to select your health insurance as an option for Personal Injury Protection (PIP) insurance coverage.

The State of New Jersey will pursue and recover any UnitedHealthcare paid benefits for services if:

- The member was covered by another health insurance including but not limited to, coverage by any health care insurer, Managed Care Organization (MCO), Medicare or an employer-administered ERISA plan;
- The member had casualty insurance including but not limited to, no-fault auto insurance benefits, workers' compensation benefits and medical payments coverage through a homeowner's insurance policy;
- The member had legal causes of action for damages instituted on behalf of an FFS member against a third party or when the State receives notice that legal counsel has been retained by or on behalf of any member; or
- The member is deceased, was age 55 or older and had an estate.

For more information on other insurance, please refer to **UHCCommunityPlan.com**. Please see the member information section. Under the Third Party Liability heading there is a link to a publication put out by the State called "When You Have Medicaid and Other Insurance" **http://nj.gov/humanservices/dmahs/home/Medicaid_TPL_Coverage_Guide.pdf**. If you have any questions, call Member Services at **1-800-941-4647**, TTY **711**.

Medicaid benefits received after age 55

Medicaid benefits received after age 55 may be reimbursable to the State of New Jersey from the member's estate. The recovery may include premium payments made on behalf of the member to the managed care organization in which the member enrolls.

Leaving UnitedHealthcare

UnitedHealthcare wants you to be pleased with our health plan. Members may leave UnitedHealthcare without cause during the first 90 days after the date of enrollment and without any cause during the State's annual open enrollment period from October 1st to November 15th. If you decide to leave the health plan outside of this time frame, you must have good cause. If you are dissatisfied with the determination that there is not good cause for disenrollment you may request and receive a State Fair Hearing if you are an NJ FamilyCare A or ABP member.

Members may leave UnitedHealthcare without cause during the first 90 days after the date of enrollment and also without any cause during the State's annual open enrollment period from October 1 to November 15.

If you decide to leave UnitedHealthcare, please call the HBC. The New Jersey Division of Medical Assistance and Health Services (DMAHS) must approve your disenrollment. It can take from 30–45 days to process your disenrollment request. The HBC will let you know when you will be effective with the new health plan. UnitedHealthcare will continue to provide services until the disenrollment date.

If you regularly refuse to follow your doctor's instructions about treatment, cooperate with your doctors, follow our rules or commit fraud, you may be disenrolled from UnitedHealthcare. If this happens, UnitedHealthcare will send you a letter to explain the disenrollment process. You still have the right to refuse any treatment you don't want to have.

If you move out of New Jersey, you may need to leave UnitedHealthcare. As soon as UnitedHealthcare learns of your new location, we'll ask the New Jersey Division of Medical Assistance and Health Services to disenroll you because you moved. Call Member Services at **1-800-941-4647**, TTY **711**, to see if this affects you.

Enrollments and disenrollment are always subject to verification and approval by DMAHS. For more information, call the HBC at 1-800-701-0710 (TTY 1-800-701-0720).

Renewing your coverage

You may lose coverage if you fail to renew with NJ FamilyCare Health Benefits Coordinator (HBC), the Social Security Administration or with your local county welfare agency (CWA). You must renew each year to keep your coverage. Here's how:

Social Security Income (SSI) members:

- Contact your local Social Security Administration (SSA) office

NJ FamilyCare members:

- The HBC, on behalf of the NJ FamilyCare program, will send your preprinted renewal application directly to your house if you are eligible through the HBC
- The CWA will send a renewal application to your house if you are eligible through the CWA
- Fill it out and send it back to NJ FamilyCare
- Call the HBC at 1-800-701-0710 (TTY 1-800-701-0720) if you have any questions or need help

Remember, if you do not renew with the NJ FamilyCare program annually, you will be dropped from the program and may not be allowed to re-enroll.

NJ FamilyCare members:

- To avoid a gap in your coverage, you must renew your health coverage before your termination date to continue to receive your medical benefits. If you do not, you could lose both your FFS health coverage and your UnitedHealthcare benefits.
- To remain enrolled, call your case worker to make sure there is no break in your health coverage one month before your termination date. Continuous enrollment means that if there is no break in your health coverage, your health plan enrollment will continue automatically.
- If you move, contact the entity where you applied and inform them of your address so that you receive your renewal application at your new address
- If you are a new mother, don't forget to enroll your newborn baby with your local county welfare agency (CWA) or NJ FamilyCare HBC

What happens when you delay in renewing your health benefits until after your termination date? You will lose your UnitedHealthcare and FFS benefits until you contact the CWA office or NJ Family Care HBC. You will be automatically re-enrolled in UnitedHealthcare if you lost your eligibility for 2 months or less. The CWA office or NJ FamilyCare HBC will let you know when you will rejoin UnitedHealthcare. To keep your benefits without any breaks, renew as soon as you get the notice from the CWA office or the NJ FamilyCare Program.

Timing of disenrollments

If you are an FFS or an NJ FamilyCare member, you may disenroll from our health plan:

1. Any time during the first 90 days of enrollment.
2. For good cause at any time.
3. During the State's Open Enrollment Period every October 1 through November 15.
4. If we fail to provide you with any of the services in this handbook, including physical access to our office.
5. If you have filed a grievance/appeal with us and have not received a response within the specified time period (see page 101).
6. If your grievance/appeal has been documented and not met with satisfaction.
7. If an exemption situation exists in our health plan and another health plan can accommodate your needs.
8. If you have substantially more convenient access to a PCP who participates in another health plan.
9. Poor quality of care.

The State will hold an Open Enrollment Period every October 1 – November 15. If you choose a new health plan during the Open Enrollment Period, the effective date will be January 1 and continue through the calendar year.

Treatment of minors

If you are a minor under age 19, you have the right to approve your own health care in some situations (for example, if you're pregnant). You may also review information that helps your doctor make decisions. You have the right to ask for and receive a copy of the clinical guidelines that are used to make decisions about your health. These rights also apply to certain minors with disabilities.

If you have an emergency and need immediate attention to preserve life and limb, you will receive that care regardless of whether we have your consent. Minors are informed of their rights as a part of the grievance process. If you have any questions about your rights, call Member Services at **1-800-941-4647**, TTY **711**.

Terms to remember

Here are some definitions of important terms we use in this Member Handbook.

ABD (Aged, Blind and Disabled) — Members of the eligibility category of Aged, Blind and Disabled and are eligible for enrollment in the managed care program.

Abuse — Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the NJ FamilyCare program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the NJ FamilyCare program.

Affordable Care Act (ACA) — Federal Health Reform Statute signed into law in March 2010, also known as the Patient Protection and Affordable Care Act.

Alternative Benefit Plan (ABP) — Benefit package for individuals in the new adult group (NJ FamilyCare Expansion) under the Affordable Care Act (ACA).

Appeal — A request by a member or provider for review of an action.

Appointment — A scheduled meeting with a doctor.

Authorized Person or Authorized Representative — In general, means a person authorized to make medical determinations for a member, including, but not limited to, enrollment and disenrollment decisions and choice of a PCP.

Baseline Exam — A complete physical exam as soon as you join a health plan. When your PCP gives you a physical examination, he or she will ask questions about your health history.

Complaint — See grievance.

Critical Incident — An occurrence involving the care, supervision, or actions of a member that is adverse in nature or has the potential to have an adverse impact on the health, safety, and welfare of the member or others. Critical incidents also include situations occurring with staff or individuals or affecting the operations of a facility/institution/school.

Division of Developmental Disabilities (DDD) — Division of Developmental Disabilities (DDD)/ MLTSS Referral — Any Medicaid member or potential Medicaid member who has an ID/DD/or related condition who is interested in Managed Long Term Services and Supports Program must be screened by the Division of Developmental Disability for the appropriate state program. Through this screen the member/potential member will be options counseled and given the opportunity to choose the most appropriate program.

DDD — Division of Developmental Disabilities. Its clients can be enrolled in the managed care program.

DDD/CCW — Division of Developmental Disabilities/Community Care Waiver. Its clients can be enrolled in the managed care program.

Disenrollment — When you are leaving UnitedHealthcare. To disenroll, you have to call your county welfare agency, the Medical Assistance Customer Center or the Health Benefits Coordinator.

Division of Disability Services (DDS) — Within the Department of Human Services, the Division of Disability Services (DDS) serves as a single point of entry for individuals with disabilities and their families to obtain resources and assistance connecting to available supports. In addition to providing comprehensive Information and referral services, DDS administers the Traumatic Brain Injury Fund (TBI Fund) and the Personal Assistance Services Program (PASP) initiates MLTSS enrollment for children ages 20 and younger, promotes and provides technical assistance for NJ ABLE and NJ WorkAbility and seeks to advance disability health and wellness initiatives. As the lead state agency on disabilities, the Division aims to ensure that the needs of individuals with disabilities and represented in policy, planning and decision making, as we promote greater access, equity and inclusion in all areas of life: health, education, employment, recreation and social engagement.

Doula — Doulas work in a variety of settings and have been trained to provide physical, emotional, and informational support to a mother before, during, and just after birth and/or provide emotional and practical support to a mother during the postpartum period. A doula does not replace a doctor or midwife and cannot deliver a baby.

Emergency — A health problem that an average person with a basic understanding of medicine and health could reasonably expect not taking immediate medical attention to result in (1) placing the health of the person (with respect to a pregnant woman, the health of the woman or her unborn child) that has such condition in serious danger, or in the case of a behavioral condition, placing the health of such person or others in serious danger; or (2) serious injury of bodily functions; or (3) serious dysfunction of any bodily organ or part; or (4) serious disfigurement or (5) possibly death.

Enrollment — Joining UnitedHealthcare.

Family Planning — The family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, or a medical visit to change the method of contraception. Also includes, but is not limited to sterilizations, defined as any medical procedures, treatments, or operations for the purpose of rendering an individual permanently incapable of reproducing. Abortions (and related services) and infertility treatment services are excluded.

Family Practice Provider — A doctor who is trained to take care of children and adults.

Federal Poverty Level — Income thresholds determined by the U.S. Department of Health and Human Services; used as a measure to determine if a person or family is eligible for assistance through various federal programs; for example, NJ FamilyCare.

Fraud — An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Grievance — A grievance is an expression of dissatisfaction about any matter, a complaint, or a protest by a member as to the conduct by UnitedHealthcare Community Plan or any in-network provider. It could also be a failure to act by UnitedHealthcare Community Plan or any in-network provider on behalf of our members, or any other matter in which a member feels unfairly treated by UnitedHealthcare Community Plan verbally or in writing.

Home and Community Based Services (HCBS) — Services above state plan limits that are provided as an alternative to long-term institutional services in a nursing facility. HCBS includes personal care assistance and medical day care when they are above the limits established under New Jersey's State Plan. HCBS are provided to individuals who meet MLTSS eligibility requirements and reside in the community or in certain community alternative residential settings.

Immunizations — Shots for adults, children, adolescents, infants and for babies during the first two years that protect from certain diseases.

Internist — A doctor trained to give basic preventive care, complete exams, and administer immunizations for adults.

Lactation Services — A process that provides support for women who want to breastfeed by means of counseling, breastfeeding classes, breast pumps and supplies, and the provision of breastfeeding educational materials to help reinforce a healthy and successful breastfeeding routine.

Managed Care — A comprehensive approach to the provision of health care which combines clinical preventive, restorative, and emergency services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other medically necessary health care services in a Cost Neutral manner.

Managed Long-Term Services and Supports (MLTSS) — A program that applies solely to individuals who meet MLTSS eligibility requirements and encompasses the NJ FamilyCare A benefit package, NJ FamilyCare ABP (excluding the ABP Mental Health/Substance Use benefit), Home and Community Based Services (HCBS) and institutionalization for long-term care in a nursing facility or special care nursing facility.

Managed Long-Term Services and Supports (MLTSS) Pediatric Level of Care — A child (ages birth to 20) must be clinically eligible for MLTSS services when: The child exhibits functional limitations, identified in terms of developmental delay or functional limitations in specific age-appropriate activities of daily living, requiring nursing care over and above routine parenting and meets nursing care criteria as outlined in the 1115c Comprehensive waiver STC 32.

Medicaid and Other Insurance — Please refer to pages 6–8 and 14–15 in the *When You Have Medicaid and Other Insurance Guide*. **http://www.nj.gov/humanservices/dmahs/home/Medicaid_TPL_Coverage_Guide.pdf**

Medical Day Care (Adult Day Health Services) — A program that provides preventive, diagnostic, therapeutic, and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive imparements in order to support their community living.

Medically Necessary Care — Services or supplies needed to prevent or diagnose and cure conditions that would cause suffering, endanger a person's life, result in illness or limit a person's normal activities.

Member — A person who is enrolled with UnitedHealthcare.

Member ID Card — A card issued by UnitedHealthcare that says you are a member. The ID card has your member ID number and tells you how to call us. Providers and pharmacies (if necessary) will ask for this card. Carry your member ID card and your Health Benefits ID (HBID) card at all times.

Member Services — The toll-free UnitedHealthcare phone number you can call 24 hours a day, 7 days a week when you have questions or problems with your health insurance. The number is **1-800-941-4647**, TTY **711**, for English and translations.

Non-Participating Provider (non-par) — A provider who is not contracted as part of the UnitedHealthcare network. If you see a non-par provider without a referral or medical authorization, you will have to pay the bill. This is also known as out-of-network provider.

Nurse Practitioner — An Advanced Practice Registered Professional Nurse who works under the direction of a physician to give basic preventive care and immunizations for children and adults.

Participant Risk Assessment — The NJ Choice assessment system is utilized to identify a member's risk factors for all active and potential MLTSS members in or seeking community placement. In addition to the NJ Choice assessment system, the Contractor shall assess the potential for risk as it relates to the following elements of risk in a community setting: home environment; physical health and wellness; behavioral health; personal safety; emergency planning; caregiver support; psychosocial; financial resources.

Participating Provider — A provider that is part of the UnitedHealthcare provider network. This is also known as an in-network provider.

Pediatrician — A doctor who is trained to take care of babies and children under 21 years old.

Peer Recovery Support Services (PRSS) — PRSS workers are people who have been successful in the recovery process who help others that are experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process, thereby reducing the likelihood of a relapse.

Post-Stabilization Care — Care to maintain or improve your health once an emergency is stabilized.

Prenatal Care — The health care a woman receives before the birth of her baby.

Preventive Care — Health care that prevents serious disease (e.g., regular checkups, immunizations, well-child and well-woman care, dental screenings, lead screenings).

Primary Care Dentist (PCD) — A PCD may be a general dentist or pediatric licensed dentist (pedodontist) who is the health care provider responsible for supervising and coordinating initial and primary care to patients, for initiating referrals for specialty care and for maintaining continuity of patient care.

Primary Care Provider (PCP) — A licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner who gives you care, arranges your specialty care and keeps your medical records. Your PCP will also be a participating provider.

Prior Authorization — A request from your doctor to UnitedHealthcare to let you see a non-participating doctor, hospital or other services prior to you receiving those services.

Provider — A physician, dentist, hospital, group practice, nursing home, pharmacy or any individual or group of individuals that offers health care services.

Provider Directory — List of providers who are part of the UnitedHealthcare network.

Referral — Approval from a PCP to see a participating specialist. The PCP can refer you to a specialist and may even help you make your first appointment.

Screen for Community Services (SCS) — Is a NJ State mandated screening tool that has an algorithm based on level of care questions, scores a level of service score outcome which identifies individuals most in need of MLTSS services. The screen is required for all individuals requesting MLTSS.

Special Care Nursing Facility (SCNF) — A special care nursing facility or separate and distinct SCNF unit within a Medicaid-certified conventional nursing facility which has been approved by the State to provide care to Medicaid/NJ FamilyCare beneficiaries who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility.

Specialist — A provider who is trained in a special type of medicine, dentistry or health care. Your PCP will give you a referral to see a specialist when necessary.

UnitedHealthcare Dual Complete — The managed Medicare Special Needs program for people who have both Medicaid and Medicare Parts A and B.

Urgent Care — Treatment within 24 hours for a problem that is serious but not life-threatening.

Waste — Overutilization of services or other practices that result in unnecessary costs. Waste isn't usually caused by criminally negligent actions, but rather the misuse of resources.

Health Plan Notices of Privacy Practices

THIS NOTICE SAYS HOW YOUR MEDICAL INFORMATION MAY BE USED. IT SAYS HOW YOU CAN ACCESS THIS INFORMATION. READ IT CAREFULLY.

Effective January 1, 2019.

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 email. 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 Use or Share Your Information

We must use and share your HI with:

- You or your legal representative
- Government agencies

We have the right to 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 use or share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may 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 use your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may use your HI to send you appointment reminders and information about your health benefits.

We may use or share your HI as follows:

- **As Required by Law.**
- **To Persons Involved With Your Care.** This may be to a family member 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 when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI. 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)**.

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 **711**.
- **To Submit a Written Request.** Mail to:

  UnitedHealthcare Privacy Office
  MN017-E300
  P.O. Box 1459
  Minneapolis, MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

[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, Inc.; Symphonix Health Insurance, Inc.; 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 Insurance Company; 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.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is completed as of the effective date of this notice. For a current list of health plans subject to this notice go to **www.uhc.com/privacy/entities-fn-v2-en** or call the number on your health plan ID card.

Financial Information Privacy Notice

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

Effective January 1, 2019.

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 your health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-866-633-2446**, or TTY **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: AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; Lifeprint East, Inc.; Lifeprint Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Optum Women's and Children's Health, LLC; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services LLC; and UnitedHealthcare Services Company of the River Valley, 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 completed as of the effective date of this notice. For a current list of health plans subject to this notice, go to **www.uhc.com/privacy/entities-fn-v2-en** or call the number on your health plan ID card.

UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

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

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan member ID card, TTY **711**, 24 hours a day, 7 days a week.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

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

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

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

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

If you need help with your complaint, please call the toll-free member phone number listed on your member ID card.

We provide free services to help you communicate with us, such as letters in other languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY **711**, 24 hours a day, 7 days a week.

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If the enclosed information is not in your primary language, please call UnitedHealthcare Community Plan at 1-800-941-4647, TTY 711

Yog cov ntaub ntawv muab tuaj hauv no tsis yog sau ua koj hom lus, thov hu rau UnitedHealthcare Community Plan ntawm 1-800-941-4647, TTY 711.

Afai o fa'amatalaga ua tuuina atu e le'o tusia i lau gagana masani, faamolemole fa'afesoota'i mail e vaega a le UnitedHealthcare Community Plan ile telefoni 1-800-941-4647, TTY 711.

Если прилагаемая информация представлена не на Вашем родном языке, позвоните представителю UnitedHealthcare Community Plan по тел. 1-800-941-4647, телетайп 711.

Якщо інформація, що додається, подана не на Вашій рідній мові, зателефонуйте до UnitedHealthcare Community Plan 1-800-941-4647 для осіб з порушеннями слуху 711.

동봉한 안내 자료가 귀하의 모국어로 준비되어 있지 않으면 1-800-941-4647, TTY 711 로 UnitedHealthcare Community Plan 에 전화주십시오.

Dacă informațiile alăturate nu sunt în limba dumneavoastră principală, vă rugăm să sunați la UnitedHealthcare Community Plan, la numărul 1-800-941-4647 TTY 711.

ተያይዞ ያለው መረጃ በቋንቋዎ ካልሆነ እባክዎን በሚከተለው ስልክ ቁጥር ወደ UnitedHealthcare Community Plan ይደውሉ። 1-800-941-4647። መስማት ለተሳናቸው TTY 711።

ተተሓሒዙ ዘሎ ሓበሬታ ብቋንቋኹም ተዘይኮይኑ፤ ብኽብረትኩም በዚ ዝስዕብ ቁጽሪ ስልኪ ናብ UnitedHealthcare Community Plan ደውሉ፦ 1-800-941-4647 ምስማዕ ንተጸገሙ/TTY 711።

Si la información adjunta no esta en su lengua maternal, llame a Unitedhealthcare Community Plan al 1-800-941-4647, TTY 711.

ຖ້າຂໍ້ມູນທີ່ຄັດມານີ້ບໍ່ແມ່ນພາສາຕົ້ນຕໍຂອງທ່ານ, ກະລຸນາໂທຫາ UnitedHealthcare Community Plan ທີ່ເບີ 1-800-941-4647, TTY 711.

Nếu ngôn ngữ trong thông tin đính kèm này không phải là ngôn ngữ chánh của quý vị, xin gọi cho UnitedHealthcare Community Plan theo số 1-800-941-4647, TYY 711.

若隨附資訊的語言不屬於您主要使用語言，請致電 UnitedHealthcare Community Plan，電話號碼為 1-800-941-4647 聽障專線 TTY 711。

ប្រសិនបើព័ត៌មានដែលភ្ជាប់មកនេះមិនមែនជាភាសាដើមរបស់អ្នកទេ សូមទូរស័ព្ទមកកាន់ UnitedHealthcare Community Plan លេខ 1-800-941-4647, សម្រាប់អ្នកថ្លង់ TTY 7111។

Kung ang nakalip na impomasyon ay wala sa iyong panguhanig wika, mangyaring tumawaga sa UnitedHealthcare Community Plan sa 1-800-941-4647 (TTY: 711).

در صورت اینکه اطلاعات پیوست به زبان اولیه شما نمیباشد، لطفا با United Healthcare Community Plan با شماره 1-800-941-4647 تماس حاصل نمایید وسیله ارطباتی برای نا شنوایان-TTY 711.

We're here for you

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-941-4647**, TTY **711**, 24 hours a day, 7 days a week. You can also visit our website at **myuhc.com/CommunityPlan**.

UnitedHealthcare Community Plan
P.O. Box 2040
Edison, NJ 08818-2040

myuhc.com/CommunityPlan

1-800-941-4647, TTY **711**

United Healthcare
Community Plan


United
Healthcare
Community Plan