Welcome to the community.

New Jersey

- Welcome
- Member Handbook
- Other Information
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, 8:00 a.m. to 6:00 p.m. EST Monday through Friday. If you call after-hours, you may leave a voicemail, and we will return your call the next business day.
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 11.

3. **Get to know your health plan.** Start with the Health Plan Highlights section on page 9 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 8:00 a.m. to 6:00 p.m. toll-free at **1-800-941-4647** or **TTY: 711**. If you call after-hours, you may leave a voicemail, and we will return your call the next business day. 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. Sometimes we need to call you. Please call us at 1-800-941-4647, TTY: 711, with a telephone number that you would like us to use for you so that we can 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, 8:00 a.m. to 6:00 p.m. EST Monday through Friday. If you call after-hours, you may leave a voicemail, and we will return your call the next business day. For better health care, UnitedHealthcare Community Plan is here for you.

Sincerely,

Scott Waulters, President
UnitedHealthcare Community Plan
## Table of Contents

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Health Plan Highlights</td>
</tr>
<tr>
<td>9</td>
<td>Member ID Card</td>
</tr>
<tr>
<td>10</td>
<td>Benefits at a Glance</td>
</tr>
<tr>
<td>11</td>
<td>Your Health Assessment</td>
</tr>
<tr>
<td>12</td>
<td>Member Support</td>
</tr>
<tr>
<td>14</td>
<td>Using Your Pharmacy Benefit</td>
</tr>
<tr>
<td>16</td>
<td>Going to the Doctor</td>
</tr>
<tr>
<td>16</td>
<td>Your Primary Care Provider (PCP)</td>
</tr>
<tr>
<td>18</td>
<td>Annual Checkups</td>
</tr>
<tr>
<td>19</td>
<td>Making an Appointment With Your PCP</td>
</tr>
<tr>
<td>22</td>
<td>Preparing for Your PCP Appointment</td>
</tr>
<tr>
<td>22</td>
<td>If You Need Care and Your Provider’s Office Is Closed</td>
</tr>
<tr>
<td>23</td>
<td>Referrals and Specialists</td>
</tr>
<tr>
<td>24</td>
<td>Getting a Second Opinion</td>
</tr>
<tr>
<td>24</td>
<td>Prior Authorizations</td>
</tr>
<tr>
<td>25</td>
<td>Continued Care if Your PCP Leaves the Network</td>
</tr>
<tr>
<td>25</td>
<td>If You Need Care When Out of Town</td>
</tr>
<tr>
<td>25</td>
<td>Transportation Services</td>
</tr>
<tr>
<td>26</td>
<td>Hospitals and Emergencies</td>
</tr>
<tr>
<td>26</td>
<td>Emergency Care</td>
</tr>
<tr>
<td>26</td>
<td>Urgent Care</td>
</tr>
<tr>
<td>27</td>
<td>Hospital Services</td>
</tr>
<tr>
<td>27</td>
<td>Emergency Dental Care</td>
</tr>
<tr>
<td>27</td>
<td>Post-Stabilization Services</td>
</tr>
<tr>
<td>27</td>
<td>No Medical Coverage Outside of United States</td>
</tr>
<tr>
<td>28</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>28</td>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>29</td>
<td>Over-the-Counter (OTC) Medicines</td>
</tr>
<tr>
<td>29</td>
<td>Injectable Medicines</td>
</tr>
<tr>
<td>30</td>
<td>Pharmacy Home</td>
</tr>
</tbody>
</table>
31 Benefits
31 Benefits Summary
54 Behavioral Health (Mental Health/Substance Abuse) Services
55 Special Needs Members
56 Cultural and Linguistic Services
56 Managed Long-Term Services and Supports (MLTSS) Members
60 Disease and Care Management
60 Wellness Programs
60 Vision Exams
62 For Moms-to-Be and Children
64 Preventive Health Care

65 Other Plan Details
65 Finding a Network Provider
65 Provider Directory
65 New Technology Assessment
66 Interpreter Services and Language Assistance
66 Updating Your Information
67 Fraud, Waste and Abuse
67 Your Opinion Matters
67 Utilization Management
68 Advance Directives and Living Wills
68 Member Rights and Responsibilities
71 New Jersey HMO Consumer Bill of Rights
72 NJ FamilyCare
77 Appeals and Grievances
81 If You Get a Bill
82 Other Insurance
83 Leaving UnitedHealthcare
85 Treatment of Minors
86 Terms to Remember
90 Health Plan Notices of Privacy Practices
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.

Our staff is available to you to answer your questions and to help you get quality health care. You can call Member Services at 1-800-941-4647, TTY: 711, 8:00 a.m. to 6:00 p.m. EST Monday through Friday. If you call after-hours, you may leave a voicemail, and we will return your call the next business day.

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.
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.
Health Plan Highlights

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 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 23.

**Medicines.**
Your plan covers prescription drugs for members of all ages. Members in NJ FamilyCare C and D, with some exceptions, will have a co-pay. 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.
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. And it helps us match you with 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.

Call 1-800-941-4647, TTY: 711, 8:00 a.m. to 6:00 p.m. EST Monday through Friday. If you call after-hours, you may leave a voicemail, and we will return your call the next business day.

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. 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
(8:00 a.m. to 6:00 p.m. EST Monday through Friday.
If you call after-hours, you may leave a voicemail,
and we will return your call the next business day.)

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 in MLTSS should call their local MACC office for mental health services. For substance abuse services for members who are not DDD clients or not in MLTSS, call the NJ Addiction Services Hotline at 1-844-276-2777, TTY: 711, 24 hours a day, 7 days a week.
You can start using your pharmacy benefit right away.

Your plan covers a long list of medicines, or prescription drugs. Medicines that are covered are on the plan’s Preferred Drug List. Your doctor uses this list to make sure the medicines you need are covered by your plan. You can find the Preferred Drug List online at myuhc.com/CommunityPlan. You can also search by a medicine name on the website. It’s easy to start getting your prescriptions filled. Here’s how:

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.
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.

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.

**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.
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.
- Referral to dentist for all children, beginning at one year of age.
- Other health concerns.

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.

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.
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.
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.

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.

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.

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.
Going to the Doctor

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.

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 shots you need. And if there is a health problem, they’re usually much easier to treat when caught early.

Here are some important 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.

**For men.**
- Testes exam — helps detect testicular cancer.
- Prostate exam — helps detect prostate cancer.

**Well-child visits.**
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 tests, dental screenings, and immunizations 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.

**Checkup schedule.**
It’s important to schedule your well-child visits for these ages:
- 3 to 5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- 4 years
- Once a year after age 5
Here are shots 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.

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**Making an Appointment With Your PCP**

Call your doctor’s 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. This is how quickly you can expect to be seen:

<table>
<thead>
<tr>
<th>Category</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>Immediately</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours.</td>
</tr>
<tr>
<td>(conditions that are not life-threatening)</td>
<td></td>
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</tbody>
</table>
## Going to the Doctor

<table>
<thead>
<tr>
<th><strong>How long it should take to see your PCP or Dentist:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptomatic Acute Care</strong></td>
<td>Within 72 hours.</td>
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<tr>
<td>(you don’t feel well, but aren’t in danger)</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Care</strong></td>
<td>Within 28 days.</td>
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<tr>
<td>(preventive care like an annual exam or a checkup on medications)</td>
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<tr>
<td><strong>Specialist Referrals</strong></td>
<td>Within 4 weeks or less.</td>
</tr>
<tr>
<td><strong>Urgent Specialty Care</strong></td>
<td>Within 24 hours of referral.</td>
</tr>
<tr>
<td><strong>Baseline Physicals</strong></td>
<td>Within 180 calendar days of initial enrollment.</td>
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<tr>
<td>(for adults)</td>
<td></td>
</tr>
<tr>
<td><strong>Baseline Physicals</strong></td>
<td>Within 90 days of initial enrollment, or for children as required by EPSDT (well-child) guidelines.</td>
</tr>
<tr>
<td>(for children under 21 and adult DDD clients)</td>
<td></td>
</tr>
<tr>
<td><strong>Lab and Radiology Results</strong></td>
<td>Within 24 hours in urgent or emergent cases. Within 10 business days for non-urgent or non-emergent cases.</td>
</tr>
<tr>
<td><strong>Lab and Radiology Services</strong></td>
<td>Three weeks for routine appointments; 48 hours for urgent care.</td>
</tr>
<tr>
<td><strong>Prenatal Care</strong></td>
<td>Within:</td>
</tr>
<tr>
<td>(pregnant women)</td>
<td>• 3 weeks of a positive pregnancy test (home or lab).</td>
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<tr>
<td></td>
<td>• 3 days of identification of high risk.</td>
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<tr>
<td></td>
<td>• 7 days of request in 1st and 2nd trimester.</td>
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<tr>
<td></td>
<td>• 3 days of 1st request in 3rd trimester.</td>
</tr>
<tr>
<td><strong>Routine Physicals</strong></td>
<td>Within 4 weeks for routine physicals needed for school, camp, work, etc.</td>
</tr>
</tbody>
</table>
How long it should take to see your PCP or Dentist:

<table>
<thead>
<tr>
<th>Waiting Time in Office</th>
<th>Less than 45 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Pediatric Appointments</strong></td>
<td>Within 3 months of enrollment; UnitedHealthcare will call you to arrange an appointment.</td>
</tr>
</tbody>
</table>
| **Dental Appointments**                 | • Baseline exam within 2 weeks.  
                                           • Emergency dental treatment within 48 hours of injury, uncontrolled bleeding or infection involving teeth or gums (less for a more serious condition), with follow-up treatment by a dental provider.  
                                           • Urgent care appointments within 3 days.  
                                           • Routine, non-symptomatic appointments within 30 days. |
| **Mental Health/Substance Abuse Appointments** | • Emergency services: immediately.  
                                           • Urgent care appointments: within 24 hours.  
                                           • Routine care appointments: within 10 days. |
| (for DDD clients and MLTSS members only) |                       |
| **SSI and New Jersey Care**             | 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. |
| (ABD elderly and disabled enrollees)    |                       |
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.

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. 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 Abuse Professionals.
- Chiropractors.
- Dentists, including Pediatric Dentists or other Dental Specialists.

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 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.

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.
- 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 a short time 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, you will qualify if you are getting chemotherapy for cancer or are at least six months pregnant when your 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 an ambulance in a medical emergency for all members. Sometimes you may need a ride to the doctor because you have a severe injury or illness. When this happens, your PCP will work with FFS. To ask for these services, call LogistiCare at 1-866-527-9933 or TTY: 1-866-288-3133.
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:

- Serious illness.
- Poisoning.
- Broken bones.
- Severe cuts or burns.
- Heart attack.
- 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.

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.
- Flu.
- Ear infection.
- Low-grade fever.
- Minor cuts or burns.
- 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.

Don’t wait.

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

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.

**Emergency Dental Care**

Emergency dental care services to treat facial trauma, control pain, infection, uncontrolled bleeding or facial swelling are covered by your plan.

**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.
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.

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.

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.

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 co-pay) for their prescriptions. If you have a co-pay, the amount is on the front of your member ID card.
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.

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**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.

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

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**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 a pharmacy home. In this case, members must fill prescriptions at a single pharmacy location for up to two years. 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 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. To change pharmacies during this time, call Member Services at 1-800-941-4647, TTY: 711. After 30 days from the date of the letter, you will need to make your request in writing. Send your request to:

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

Members who have a pattern of misusing prescription or OTC drugs may be required to use only one pharmacy to fill their prescriptions. This is called a “lock-in.” If this happens, UnitedHealthcare will send you a letter and ask you to choose a pharmacy designated for the lock-in. This pharmacy will have to be in-network. If you do not select a pharmacy, one will be selected for you. 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 wish to appeal this restriction, you may file an appeal within 90 days of our denial decision. You should call Member Services at 1-800-941-4647, TTY: 711, to file an appeal. We recommend that you follow your call with a written request. NJ FamilyCare A and ABP members also have the right to request a Medicaid Fair Hearing. If you are eligible for a Medicaid Fair Hearing, you must do so within 20 days from the date of the notification letter. Request for a fair hearing should be sent to:

DMAHS
Fair Hearing Unit
P.O. Box 712
Trenton, NJ 08625-0712
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 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.
## Summary of Benefits

<table>
<thead>
<tr>
<th>Benefits (Subject to health plan policies and procedures)</th>
<th>NJ FamilyCare A</th>
<th>NJ FamilyCare ABP</th>
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<th>DDD Clients</th>
<th>NJ FamilyCare B and C</th>
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</thead>
<tbody>
<tr>
<td>Abortion and Related Services</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
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<tr>
<td>Acupuncture</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Adult Family Care</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
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<tr>
<td>Allergy Testing</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
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<tr>
<td>Assisted Living Services (ALR, CPCH)</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
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<tr>
<td>Assisted Living Programs (ALP)</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
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<tr>
<td>Audiology</td>
<td>Covered</td>
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**FFS** – The member is covered using Health Benefits ID card. Services are approved by the FFS provider.

**Member May Self-Refer** – The member may choose a doctor from the UnitedHealthcare provider network.

**ABD** – Aged, Blind, and Disabled

**MLTSS – Managed Long-Term Services and Supports** – A program that applies solely to individuals who meet MLTSS eligibility requirements and encompasses the NJ FamilyCare A benefit package, NJ FamilyCare ABP benefit (excluding the ABP Mental Health/Substance Abuse benefit), Home and Community Based Services (HCBS) and institutionalization for long-term care in a nursing facility or special care nursing facility.
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</thead>
<tbody>
<tr>
<td>Blood and Plasma Products</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
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<tr>
<td>Bone Mass Measurement (Bone Density)</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
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<tr>
<td>Caregiver/Participant Training</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
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<tr>
<td>Case Management</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Chiropractor Services (Manual Manipulation of Spine)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
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<tr>
<td>Chore Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
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<tr>
<td>Cognitive Therapy</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered Limited to 60 visits, per therapy, per incident, per calendar year</td>
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<tr>
<td>Colorectal Screening Exams</td>
<td>Covered Member age 50 and over may self-refer to network providers</td>
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<tr>
<td>Community Residential Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
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<tr>
<td>Community Transition Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>FFS if in Community Care Waiver</td>
<td>Not Covered</td>
<td>Not Covered</td>
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<tr>
<td>Court-Ordered Services</td>
<td>Covered Call Member Services for more information</td>
<td>Covered Call Member Services for more information</td>
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<td>Dental Services</td>
<td>Comprehensive Coverage</td>
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<td>Comprehensive Coverage</td>
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<tr>
<td></td>
<td>For diagnostic, preventive and routine services. May have increased frequency limits based on medical necessity. Major services require Prior Authorization and include: crowns, bridges, full dentures, partial dentures, gum treatments, root canal, extractions, complex oral surgery and orthodontics.</td>
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<tr>
<td>Orthodontic Services</td>
<td>Covered with Prior Authorization. (Only medically necessary orthodontic services are covered for children under the age of 21.)</td>
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<td>Diabetic Supplies and Equipment</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)/Assistive Technology Devices</td>
<td>Covered Prior Authorization may be required if greater than $500</td>
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<td>Durable Medical Equipment (DME)/Assistive Technology Devices</td>
<td>Limited</td>
<td>Call Member Services at 1-800-941-4647, TTY: 711</td>
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<tr>
<td>DCP&amp;P (formerly DYFS) the Division of Child Protection and Permancy Residential Treatment</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Educational or Special Remedial Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Early and Periodic Screening Diagnostic and Treatment (EPSDT) Services and Immunizations (0 – 21 yrs of age)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered with limitations (see page 63)</td>
</tr>
<tr>
<td>Emergency Room Care</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Emergency Medical Transportation (Ambulance)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
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<th>NJ FamilyCare B and C</th>
<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Eye Exams and Optometrist Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td></td>
<td>Member May Self-Refer</td>
<td></td>
<td>Member May Self-Refer</td>
<td>Member May Self-Refer</td>
<td>Member May Self-Refer</td>
<td>Member May Self-Refer</td>
</tr>
<tr>
<td>Eyeglasses (Lenses and Frames)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Members May Self-Refer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frames are limited to $100 allowance (see page 60 for limitations)</td>
<td>Frames are limited to $100 allowance (see page 60 for limitations)</td>
<td>Frames are limited to $100 allowance (see page 60 for limitations)</td>
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<td>Frames are limited to $100 allowance (see page 60 for limitations)</td>
</tr>
<tr>
<td>Family Planning Basic Services (Self-Referral Reproduction Health Procedures/Devices)</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td></td>
<td>Member May Self-Refer to participating OB/GYN FFS when furnished by a non-participating HMO doctor</td>
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<th>NJ FamilyCare B and C</th>
<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Exams and Batteries</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
</tr>
<tr>
<td>HIV/AIDS Testing</td>
<td>Member May Self-Refer</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Home Based Supportive Care</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Health Plan Highlights**

**Going to the Doctor**

**Hospitals & Emergencies**

**Pharmacy**

**Benefits**

**Other Plan Details**

**NJ FamilyCare**

**ABP**

**DDD Clients**

**NJ FamilyCare A**

**and ABP with MLTSS**

**NJ FamilyCare B and C**

**NJ FamilyCare D**

**Coverage Details**

- Hearing Exams and Batteries:
  - Covered with PCP Referral
  - Prior Authorization required if greater than $500

- Hemodialysis:
  - Covered with PCP Referral
  - Prior Authorization required if greater than $500

- HIV/AIDS Testing:
  - Member May Self-Refer

- Home Based Supportive Care:
  - Not Covered

- Home Delivered Meals:
  - Not Covered

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</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered Limited to skilled nursing and medical social services Prior authorization may be required</td>
</tr>
<tr>
<td>Hospice</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Independent Clinics and Federally Qualified Health Centers</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Infertility Testing and Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
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<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab Tests and X-Rays</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
</tr>
<tr>
<td>Mammograms (Screening)</td>
<td>Covered</td>
<td>Member May Self-Refer</td>
<td>Baseline for women 35 – 39 and annual for women 40+</td>
<td>Covered</td>
<td>Member May Self-Refer</td>
<td>Baseline for women 35 – 39 and annual for women 40+</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Medication Dispensing Device</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
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<th>NJ FamilyCare B and C</th>
<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone and Methadone Maintenance</td>
<td>Methadone for pain management is Covered by UnitedHealthcare; Methadone maintenance for substance abuse treatment is covered by FFS</td>
<td>Methadone for pain management is Covered by UnitedHealthcare; Methadone maintenance for substance abuse treatment is covered by FFS</td>
<td>Methadone for pain management and substance abuse treatment is Covered by UnitedHealthcare; Methadone maintenance for substance abuse treatment is covered by UnitedHealthcare</td>
<td>Methadone for pain management is Covered by UnitedHealthcare; Methadone maintenance for substance abuse treatment is covered by UnitedHealthcare</td>
<td>Methadone for pain management is Covered by UnitedHealthcare; Methadone maintenance for substance abuse treatment is covered by UnitedHealthcare</td>
<td>Methadone for pain management is Covered by UnitedHealthcare; Methadone maintenance for substance abuse treatment is covered by UnitedHealthcare</td>
</tr>
<tr>
<td>Nursing Facility and Special Care Nursing Facility Services</td>
<td>Covered with Prior Authorization</td>
<td>Covered with Prior Authorization</td>
<td>Covered with Prior Authorization</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Obstetrical/Maternity Care</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
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<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic Shoes</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>Covered Behavioral health visits are covered FFS</td>
<td>Covered Behavioral health visits are covered FFS</td>
<td>Covered Behavioral health visits are covered FFS</td>
<td>Covered Behavioral health visits are covered FFS</td>
<td>Covered Behavioral health visits are covered FFS</td>
<td>Covered FFS</td>
</tr>
<tr>
<td>Outpatient Surgery, Same-Day Surgery, Ambulatory Surgical Center</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Pain Management Services</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Pap Smears and Pelvic Exams</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
</tr>
<tr>
<td>Parenting/Childbirth Education</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
<td>Covered Member May Self-Refer</td>
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<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Care Assistant (PCA) Services</strong> – (in home)</td>
<td>Covered with Prior Authorization With Limitations</td>
<td>Covered with Prior Authorization With Limitations</td>
<td>Covered with Prior Authorization</td>
<td>Covered with Prior Authorization With Limitations</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Personal Emergency Response System</strong></td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>FFS if in Community Care Waiver</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Personal Preference Program Services</strong> – (Participant direction service delivery)</td>
<td>Covered with Prior Authorization</td>
<td>Covered with Prior Authorization</td>
<td>Covered with Prior Authorization</td>
<td>FFS if in Community Care Waiver</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Participation requires program approval by DDS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Podiatry Care – Medically Necessary</strong> – (Office-based, Non-surgical)</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Podiatry Care – Routine Preventive (Office-based, Non-surgical)</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Podiatry Care – Surgical</td>
<td>Covered with Referral</td>
<td>Covered with Referral</td>
<td>Covered with Referral</td>
<td>Covered with Referral</td>
<td>Covered with Referral</td>
<td>Covered with Referral</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Drug Formulary</td>
<td>Certain Over-The-Counter drugs are covered. These drugs are listed as prescription drugs on the formulary.</td>
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<td>Certain Over-The-Counter drugs are covered. These drugs are listed as prescription drugs on the formulary.</td>
<td>Certain Over-The-Counter drugs are not covered.</td>
</tr>
<tr>
<td>Post-Acute Care Preventive Health Care and Counseling and Health Promotion</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>PCP Visits</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
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</thead>
<tbody>
<tr>
<td>Private Duty or Skilled Nursing Care</td>
<td>Covered with Prior Authorization if related to EPSDT screening</td>
<td>Covered with Prior Authorization if related to EPSDT screening</td>
<td>Covered with Prior Authorization if related to EPSDT screening</td>
<td>Covered with Prior Authorization if related to EPSDT screening</td>
<td>Covered with Prior Authorization if related to EPSDT screening</td>
<td>Covered with Prior Authorization if related to EPSDT screening</td>
</tr>
<tr>
<td>Prostate Screening Exams</td>
<td>Covered Annual for men 50+; if family history, annual at age 40. Member May Self-Refer</td>
<td>Covered Annual for men 50+; if family history, annual at age 40. Member May Self-Refer</td>
<td>Covered Annual for men 50+; if family history, annual at age 40. Member May Self-Refer</td>
<td>Covered Annual for men 50+; if family history, annual at age 40. Member May Self-Refer</td>
<td>Covered Annual for men 50+; if family history, annual at age 40. Member May Self-Refer</td>
<td>Covered Annual for men 50+; if family history, annual at age 40. Member May Self-Refer</td>
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<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetics and Orthotics</td>
<td>Covered with PCP Referral Prior Authorization required if greater than $500</td>
<td>Covered with PCP Referral Prior Authorization required if greater than $500</td>
<td>Covered with PCP Referral Prior Authorization required if greater than $500</td>
<td>Covered with PCP Referral Prior Authorization required if greater than $500</td>
<td>Covered with PCP Referral Prior Authorization required if greater than $500</td>
<td>Prosthetics – Limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury, or congenital defect. Repair and replacement services are covered when due to congenital growth. Orthotics – Not Covered</td>
</tr>
<tr>
<td>Radiation/Chemotherapy/Hemodialysis</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
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<th>NJ FamilyCare D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation/Cognitive Rehabilitation (Outpatient Occupational Therapy/Physical Therapy/Speech Pathology Services)</td>
<td>Covered. Prior Authorization May Be Required</td>
<td>Covered. Prior Authorization May Be Required</td>
<td>Covered with Prior Authorization Includes habilitation and the prevention of loss of function</td>
<td>Covered. Prior Authorization May Be Required</td>
<td>Covered. Prior Authorization May Be Required Limited to 60 visits, per therapy, per incident, per calendar year</td>
<td>Covered. Prior Authorization May Be Required Limited to 60 visits, per therapy, per incident, per calendar year</td>
</tr>
<tr>
<td>Residential Modifications</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered Contact CCW Care Management</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Respite Care</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered Contact CCW Care Management</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Second Medical/Surgical Opinions</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
</tr>
<tr>
<td>Sex Abuse Examinations</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Sleep Apnea Studies</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td></td>
<td>Prior authorization may be required</td>
<td>Prior authorization may be required</td>
<td>Prior authorization may be required</td>
<td>Prior authorization may be required</td>
<td>Prior authorization may be required</td>
<td>Prior authorization may be required</td>
</tr>
<tr>
<td>Sleep Pathology</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Prior authorization may be required</td>
<td>Prior authorization may be required</td>
<td>Prior authorization may be required</td>
<td>Prior authorization may be required</td>
<td>Prior authorization may be required</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation Products</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Social Adult Day Care</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialty Physician Services</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
</tr>
<tr>
<td>Speech Tests</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
</tr>
<tr>
<td>Structured Day Program</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Supported Day Services</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
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</thead>
<tbody>
<tr>
<td>TBI Behavioral Management</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Thermograms and Thermography</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Covered with PCP Referral</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transportation – Emergency Ground</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Transportation Ambulance, Invalid Coach (non-emergency)</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transportation – Lower Mode (bus, train, car service, etc.)</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>Contact the Transportation Broker</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transportation – Non-Medical</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>Covered</td>
<td>Care required within 24 hours</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Vehicle Modifications</td>
<td>Not Covered</td>
<td>Covered within 24 hours</td>
<td>Not Covered</td>
<td>Covered with Prior Authorization</td>
</tr>
<tr>
<td>Adult Mental Health Rehabilitation (supervised residential group home)</td>
<td>Covered</td>
<td>Care required within 24 hours</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Atypical Psychotic Drugs within the Specific Therapeutic Drug Classes H7T and H7X</td>
<td>Covered</td>
<td>Care required for drugs not in our formulary</td>
<td>Covered</td>
<td>Covered with Prior Authorization</td>
</tr>
<tr>
<td>Inpatient Psychiatric Hospital Services for Individuals under 21 or 65 and over</td>
<td>Covered</td>
<td>Care required within 24 hours</td>
<td>Covered</td>
<td>Covered with Prior Authorization</td>
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**Prior Authorization** may be required for drugs not in our formulary.
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</tr>
</thead>
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<tr>
<td>Inpatient Substance Abuse (diagnosis, treatment and medically managed detoxification)</td>
<td>Covered</td>
<td>FFS</td>
<td>FFS</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered Limited to Detox Only</td>
</tr>
<tr>
<td>Intermediate Care Facilities/Intellectual Disability (ICF/ID)</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Behavioral Health Inpatient-Acute Care Hospital</td>
<td>FFS</td>
<td>FFS</td>
<td>Covered with Prior Authorization</td>
<td>Covered with Prior Authorization</td>
<td>FFS</td>
<td>FFS</td>
</tr>
<tr>
<td>Outpatient Substance Abuse (diagnosis, treatment and detoxification)</td>
<td>Not Covered</td>
<td>FFS</td>
<td>FFS for ABP with MLTSS only</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient Behavioral Health (including any testing)</td>
<td>FFS</td>
<td>FFS</td>
<td>Covered</td>
<td>Covered</td>
<td>FFS</td>
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<tbody>
<tr>
<td>Partial Care for Behavioral Health</td>
<td>FFS</td>
<td>FFS</td>
<td>Covered with Prior Authorization</td>
<td>FFS</td>
<td>FFS</td>
<td>FFS</td>
</tr>
<tr>
<td>Acute Partial Hospitalization</td>
<td>FFS</td>
<td>FFS</td>
<td>Covered with Prior Authorization Limited to 6 months</td>
<td>FFS</td>
<td>FFS</td>
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Benefits

Behavioral Health (Mental Health/Substance Abuse) Services

Most NJ FamilyCare members can get their Mental Health/Substance Abuse 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 abuse 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 abuse residential, outpatient, 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 abuse 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.
- Substance abuse (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 Abuse Services from UnitedHealthcare. In addition to the Mental Health/Substance Abuse Services listed in the Benefits Summary, UnitedHealthcare will also coordinate the following services that are not covered by UnitedHealthcare under MLTSS:

- Targeted Case Management.
- PACT.
- Statewide Clinical Outreach Program for the Elderly (SCOPE).
- Self-help centers.
- Supportive housing.
- Peer recovery support services.
- Behavioral health services covered by other sources (TPL).

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

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 63 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, Monday – Friday 8:00 a.m. – 5:00 p.m.

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. Information obtained is used to inform program policy and operations as part of the continuous quality management and oversight system.

For additional information about how to file a grievance or appeal, please refer to page 77 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.
• Service integration links.
• 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 and determining the need for and cost-effectiveness of the services within 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.
Benefits

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.
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 is defined as:
1. Theft with law enforcement involvement;
2. Severe injury or fall resulting in the need for medical treatment;
3. Medical or psychiatric emergency, including suicide attempt;
4. Medication error resulting in serious consequences;
5. Inappropriate or unprofessional conduct by a provider/agency involving the member;
6. Suspected or evidenced physical or mental abuse (including seclusion and restraints, both physical and chemical);
7. Sexual abuse and/or suspected sexual abuse;
8. Neglect/Mistreatment, including self-neglect, caregiver overwhelmed, environmental;
9. Exploitation, including financial, theft, destruction of property;
10. Failure of a member’s Back-up Plan;
11. Elopement/wandering from home or facility;
12. Eviction/loss of home;
13. Facility closure, with direct impact to member’s health and welfare;
14. Media involvement or the potential for media involvement;
15. Cancellation of utilities;
16. Natural disaster, with direct impact to member’s health and welfare;
17. Unexpected death;
18. Missing person or Unable to Contact;
19. Inaccessible for initial on-site meeting;
20. 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. 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. You will be provided with a copy of the voluntary withdrawal form and also receive a copy of the fully signed form. You will also be contacted by the state Office of Community Choice Options (OCCO) for follow-up counseling if your withdrawal from MLTSS results in loss of Medicaid coverage. This voluntary withdrawal does not necessarily mean that you will not be able to obtain NJ FamilyCare benefits.
Benefits

Disease and Care Management

If you have a chronic health condition like 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.
- Pregnancy care and parenting classes.
- Nutrition 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.

<table>
<thead>
<tr>
<th>Your Health Plan</th>
<th>Eye Exam Benefit</th>
<th>Eye Wear Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS and NJ FamilyCare A, ABP and B</td>
<td>One routine exam every year.</td>
<td>One new pair of glasses* every year or as medically necessary.</td>
</tr>
<tr>
<td>Children (Under age 21) and Adults</td>
<td>No co-pay.</td>
<td>Replacements for broken or lost glasses are covered, if medically needed.</td>
</tr>
<tr>
<td></td>
<td>Additional exams are covered if medically needed.</td>
<td></td>
</tr>
<tr>
<td>FFS and NJ FamilyCare A and ABP</td>
<td>One routine exam every year.</td>
<td>One new pair of glasses* every two years (adults 21 – 59) or every year (adults 60 and over); or as medically necessary.</td>
</tr>
<tr>
<td></td>
<td>No co-pay.</td>
<td>Replacements for broken or lost glasses are covered, if medically needed.</td>
</tr>
<tr>
<td></td>
<td>Additional exams are covered if medically needed.</td>
<td></td>
</tr>
<tr>
<td>NJ FamilyCare C</td>
<td>One routine exam every year.</td>
<td>One new pair of glasses* every year or as medically necessary.</td>
</tr>
<tr>
<td>Children (Under age 21)</td>
<td>$5 co-pay may apply.</td>
<td>Replacements for broken or lost glasses are covered, if medically needed.</td>
</tr>
<tr>
<td></td>
<td>Additional exams are covered if medically needed.</td>
<td></td>
</tr>
<tr>
<td>NJ FamilyCare D</td>
<td>One routine exam every year.</td>
<td>One new pair of glasses* every two years or as medically necessary.</td>
</tr>
<tr>
<td></td>
<td>$5 co-pay may apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional exams are covered if medically needed.</td>
<td></td>
</tr>
</tbody>
</table>

* Members who are entitled to the benefit may choose glasses (up to a $100 retail value) from a select group of frames available at participating providers. If you choose other frames, you will be told the cost. Participating providers will apply a $100 allowance against that cost. You will have to pay any remaining costs above the $100 allowance for the frames. The only exception is if special lenses are medically necessary; those lenses will be covered in full.

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 and NJ FamilyCare A, ABP, B, and C 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. Your eye doctor should call 1-800-828-1525 for authorization. NJ FamilyCare D members are limited to one pair of glasses per 24-month period, or as medically necessary.
**Benefits**

**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 above) 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.

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**For Moms-to-Be and Children**

**UnitedHealthcare Healthy First Steps™.**
Our Healthy First Steps program makes sure that both mom and baby get good medical attention.

We will help:

- Give you good advice on nutrition, fitness and safety.
- Get supplies, including breast pumps for nursing moms.
- Choose a doctor or nurse midwife.
- Schedule visits and exams.
- Arrange rides to doctor's visits.
- Connect with community resources such as Women, Infants and Children (WIC) services.
- Get care after your baby is born.
- Choose a pediatrician (child’s doctor).
- Give you family planning information.

Call us toll-free at 1-877-813-3417, TTY: 711, Monday through Friday, from 7:00 a.m. to 6:00 p.m. Central time.

Follow us on Twitter @UHCPregnantCare.

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.

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.
**Newborn babies.**
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.

**Care for children.**
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 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.

With UnitedHealthcare, your child is covered for all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services from your child’s PCP. 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).
- Physical exams.
- Eyesight and hearing tests.
- Nutrition (eating habits).
- Lab tests.
- First dental exam by age 1.
- Dental checkups twice a year as well as all needed dental treatment.
- Referrals for specialty care.
- Lead screening.
- 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.
Many of these services are already part of your child’s well-child visit. You should take your child for a well-child visit immediately after birth and at 6 weeks, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years of age, and every year through age 20.

**Note:** Treatment services for NJ FamilyCare B and C are limited to those that are provided by UnitedHealthcare or covered under the FFS program. These services include 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. NJ FamilyCare D coverage is limited to well-child care, lead screenings, treatments, dental, vision, immunizations and audiology for children under age 16.

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**Preventive Health Care**

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

- Children from birth through age 20 should have EPSDT exams, including lead screening.
- Flu or pneumonia shot.
- Breast, colorectal or prostate cancer screenings. Members ages 65-75 also need an annual mammogram and a bi-annual prostate cancer screening.
- Regular dental visits.

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

Members who are between the ages of 65 and 75 as well as members who are cognitively impaired should remember to schedule and keep appointments for: cancer screenings including — breast, colorectal and/or prostate and flu and pneumonia shots.
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-to-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. There is a listing for dentists who treat children under age 6.

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.
Other Plan Details

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.

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 insurance 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 co-pays 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 and pharmacists perform UM. We do not reward anyone for saying no to needed care. We do not offer incentives to our reviewers 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.
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. 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. Make a complaint 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.


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. 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 complaints 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 insurance. 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 complaint 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 complaint 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 complaints 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.
**Other Plan Details**

**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.*

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**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 complaint or 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. Co-pays between $1 and $10. Eskimos and Native Americans under age 19 do not have a co-pay.
2. Total annual co-pays will not be more than 5% of your family’s yearly income. It’s your responsibility to keep track of your total co-pays 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. A monthly premium depending on family income and household size. Call NJ FamilyCare at 1-800-701-0710 (TTY: 1-800-701-0720) for more information.
2. Co-payments, not to exceed $35 per service. Eskimos and Native Americans do not have a co-pay.
3. Total annual premiums and co-pays 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: Co-payments are required only if indicated on your ID card.

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient hospital visits</td>
<td>$5</td>
</tr>
<tr>
<td>Emergency services in a hospital</td>
<td>$10</td>
</tr>
<tr>
<td>Physician visits (including prenatal care visits)</td>
<td>$5</td>
</tr>
<tr>
<td>Independent clinic visits</td>
<td>$5</td>
</tr>
<tr>
<td>Podiatrist visits (no routine care)</td>
<td>$5</td>
</tr>
<tr>
<td>Optometrist visits</td>
<td>$5</td>
</tr>
<tr>
<td>Nurse midwife visits (except prenatal care visits)</td>
<td>$5</td>
</tr>
<tr>
<td>Dentist visits (except diagnostic and preventive services)</td>
<td>$5</td>
</tr>
<tr>
<td>Chiropractor visits</td>
<td>$5</td>
</tr>
<tr>
<td>Nurse practitioner visits (except preventive care services)</td>
<td>$5</td>
</tr>
<tr>
<td>Generic prescription drugs</td>
<td>$1</td>
</tr>
<tr>
<td>Brand name prescription drugs</td>
<td>$5</td>
</tr>
</tbody>
</table>
**Other Plan Details**

*(Subject to change)*

**NJ FamilyCare D co-payments.**

*Note: Co-payments are required only if indicated on your ID card.*

<table>
<thead>
<tr>
<th>Service</th>
<th>Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care/specialist physician office visits during normal office hours (except for well-child care, lead screening and treatment, age-appropriate immunizations, prenatal care)</td>
<td>$5</td>
</tr>
<tr>
<td>Primary care/specialist physician office visits during non-office hours or home visit</td>
<td>$10</td>
</tr>
<tr>
<td>Dentist visits (except for diagnostic and preventive care services)</td>
<td>$5</td>
</tr>
<tr>
<td>Initial maternity visit (to doctor or nurse midwife) during normal office hours</td>
<td>$5</td>
</tr>
<tr>
<td>Initial maternity visit (to doctor or nurse midwife) during non-office hours</td>
<td>$10</td>
</tr>
<tr>
<td>Nurse practitioners visit (except preventive services)</td>
<td>$5</td>
</tr>
<tr>
<td>Nurse practitioners visit during non-office hours (except for preventive services)</td>
<td>$10</td>
</tr>
<tr>
<td>Optometrist visits (except for newborns covered under fee-for-service)</td>
<td>$5</td>
</tr>
<tr>
<td>Podiatrist visits (foot doctor) (no routine care)</td>
<td>$5</td>
</tr>
<tr>
<td>Psychologist services</td>
<td>$5</td>
</tr>
<tr>
<td>Laboratory and X-ray services that are not part of an office visit</td>
<td>$5</td>
</tr>
<tr>
<td>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)</td>
<td>$35</td>
</tr>
<tr>
<td>Outpatient hospital clinic visits (except for preventive services)</td>
<td>$5</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>$5</td>
</tr>
<tr>
<td>Prescription drugs — more than a 34-day supply</td>
<td>$10</td>
</tr>
<tr>
<td>Hospital outpatient mental health services</td>
<td>$5</td>
</tr>
<tr>
<td>Outpatient substance abuse services for detoxification</td>
<td>$5</td>
</tr>
<tr>
<td>Outpatient rehabilitation visits</td>
<td>$5</td>
</tr>
</tbody>
</table>

**There are no co-payments 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 abuse 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 in an inpatient psychiatric institution, that is not an acute care hospital, to individuals under 65 years of age and over 21 years of age.
- 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.
Other Plan Details

- 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.

Additional NJ FamilyCare D Exclusions

The following services are not covered for NJ FamilyCare D. These exclusions include the services listed on the previous page, as well as additional exclusions.

- Services that are deemed not medically necessary.
- Intermediate care facilities/intellectual disability.
- Private duty nursing unless authorized by the contractor.
- Personal care assistant services.
- Medical day care services.
- Chiropractic services.
- Orthotic devices.
- Residential treatment center psychiatric programs.
- Religious non-medical institutions care and services.
- Durable medical equipment exception (certain items are covered, call 1-800-941-4647, TTY: 711, for a list).
- Transportation services including non-emergency ambulance, invalid coach and lower mode transportation.
- Hearing aid services and audiology exception (limited to children under 16 years).
- Blood and blood plasma, except administration of blood, processing of blood, processing fees and fees related to autologous blood donations are covered.
- Cosmetic surgery.
- Custodial care.
- Special remedial and educational services.
- Experimental and investigational services.
- Medical supplies, except diabetic supplies (certain items are covered, call 1-800-941-4647, TTY: 711, for a list).
- Infertility services.
- Rehabilitative services for substance abuse.
- Weight reduction programs or dietary supplements, except surgical operations, procedures or treatment of obesity when approved by UnitedHealthcare.
• Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery.
• Recreational therapy.
• Sleep therapy.
• Court-ordered services.
• Thermograms and thermography.
• Biofeedback.
• Radial keratotomy.
• Respite care.
• Skilled nursing facility services (except covered rehabilitation and hospice care).
• Over-the-counter drugs.
• Managed Long-Term Services and Supports (MLTSS) otherwise not listed above.

Appeals and Grievances

If you want to appeal a decision made by UnitedHealthcare.
UnitedHealthcare reviews all the care you receive to make sure it’s covered by UnitedHealthcare, FFS or the NJ FamilyCare program and is medically necessary. Any decision to deny or limit medical care will be made by a doctor at UnitedHealthcare. The doctor making the decision will talk to your doctor.

If you ever think that UnitedHealthcare has denied a service that should be covered, you, or your provider with your written consent, have the right to appeal that decision within 90 days of the date of your denial letter. This is called a Stage 1 Appeal. You can do this by calling Member Services at 1-800-941-4647, TTY: 711, and asking to have the decision reviewed. If you call, we recommend that you follow your call with a written request for each stage of an appeal. We will review your appeal as soon as possible, and always within 10 calendar days of your request. If it is a decision about urgent or emergency care, UnitedHealthcare will review it within 72 hours. You or your doctor can talk to the UnitedHealthcare medical director or the doctor who made the decision to discuss the reason for the decision.
If we still deny the service, we’ll tell you the reason in writing. If you or your doctor disagrees with our decision, you or your doctor (with your written consent) can ask for an Internal Utilization Management Appeal (Stage 2 Appeal) within 90 days of the date of your most recent denial letter. You can do this by calling Member Services at 1-800-941-4647, TTY: 711, or writing to:

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

UnitedHealthcare will write back to you within 10 business days to say we received your appeal. Doctors who have not been involved in the decision to deny the services will review your appeal. If necessary, doctors trained in the medical specialty that concerns your care will be part of the review. The panel will review your appeal as soon as possible, and always within 20 business days of getting your letter. If your appeal is about urgent or emergency care, they will respond within 72 hours. You will get a letter telling you what UnitedHealthcare has decided. The letter will also tell you how to ask for an external appeal (Stage 3 Appeal).

You or your provider (acting with your written consent) have four months after you get the decision of the Stage 2 Appeal panel to ask an Independent Utilization Review Organization (IURO) to do another review of the case (Stage 3 Appeal). You can also request a Medicaid Fair Hearing at any time within 20 days from the date of your most recent denial letter if you are eligible for a Medicaid Fair Hearing. The IURO panel is chosen by the New Jersey Department of Banking and Insurance. UnitedHealthcare will send you the forms you need to appeal to an IURO panel when we write to you about the decision of the Stage 2 Appeal panel. If you’re enrolled in NJ FamilyCare A or NJ FamilyCare ABP, you can ask for a Medicaid Fair Hearing.

To appeal to an IURO panel, you or your provider must mail the form to:

- New Jersey Department of Banking and Insurance
- Consumer Protection Services
- Office of Managed Care
- P.O. Box 329
- Trenton, NJ 08625-0329

You may also contact the Department of Banking and Insurance at the above address or by calling their toll-free number, 1-888-393-1062, if you need assistance during any stage of your appeal.

The decision of the IURO panel is binding. That means that neither you nor UnitedHealthcare may appeal their decision. If the IURO panel decides you should get the care, UnitedHealthcare will provide it. UnitedHealthcare will never penalize you or your provider for filing an appeal.
The Stage 3 External Appeal process is administered by the Division of Banking and Insurance (DOBI) and is used for the review of the appropriate utilization and medical necessity of covered health care services. The services below may not be eligible for the DOBI Stage 3 External Appeal process.

1. Adult Family Care.
2. Assisted Living Program.
3. Assisted Living Services — when the denial is not based on Medical Necessity.
5. Chore services.
7. Home Based Supportive Care.
9. PCA.
10. Respite (Daily and Hourly).
11. Social Day Care.
12. Structured Day Program — when the denial is not based on Medical Necessity.
13. Supported Day Services — when the denial is not based on the diagnosis of TBI.

You may request an expedited review of an appeal if you think a delay in service or treatment would significantly increase the risk to your health. You can do this by calling UnitedHealthcare Member Services at 1-800-941-4647, TTY: 711, and ask to have the decision reviewed urgently. UnitedHealthcare will render a decision on the expedited appeal within 72 hours of receipt of the appeal and will notify you and your doctor of the decision.

**If you have a problem.**
A complaint is a problem you have with UnitedHealthcare or an in-network provider that can be solved within 5 business days. The easiest way to get answers to your questions or to file a complaint 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 we cannot resolve your complaint within 5 business days, your complaint becomes a grievance. A grievance is any complaint we cannot resolve within 5 business days.
Other Plan Details

After 5 business days, you’ll get a letter acknowledging your grievance. UnitedHealthcare 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 your right to file grievances and appeal decisions.

If you are not satisfied with our answer, you have the right to appeal our decision by calling Member Services at 1-800-941-4647, TTY: 711, within 90 calendar days of our response to you. When you call, we will help you file your appeal.

If you still are not satisfied with our answer, you can file a formal appeal by calling Member Services at 1-800-941-4647, TTY: 711, within 90 calendar days of our response. You can send us more information that may help us decide your case. You will receive an acknowledgement letter within 10 business days. We will get back to you with a decision within 20 calendar days.

If you are still not satisfied with our response and you are a NJ FamilyCare A or NJ FamilyCare ABP member, you may ask for a Medicaid Fair Hearing with the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, within 20 calendar days of when we sent you our denial letter. You may ask for a Fair Hearing by writing to:

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

If your complaint or grievance is about a medical issue, qualified medical staff will make our decision on the matter. If you want, you can ask your doctor or someone else to represent you when you make a complaint or file a grievance. When we make a decision, we will tell you why we decided the way we did and what rights you have to appeal our decision.

All UnitedHealthcare members also have the right to call the New Jersey Division of Medical Assistance and Health Services at 1-800-356-1561 to ask for assistance.

Neither UnitedHealthcare, nor any of its providers, will ever penalize you or your provider for filing a complaint, 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.
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 your benefit package has co-pays.

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. You may also call the provider who sent you the bill, but you do not need to do that. UnitedHealthcare will fix this problem for you.
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.

If you are enrolled in UnitedHealthcare Dual Complete and UnitedHealthcare FFS, your doctor should bill UnitedHealthcare Dual Complete first.

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, worker’s 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. If you’re thinking about leaving, call Member Services or the State of New Jersey’s Health Benefits Coordinator (HBC). You can tell us your reasons for wanting to leave UnitedHealthcare in writing if you wish, too. You can call Member Services at 1-800-941-4647, TTY: 711, or a Health Benefits Coordinator (HBC) at 1-800-701-0710 (TTY: 1-800-701-0720). Reasons must be for 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 Insurance

You may lose coverage if you fail to renew with NJ FamilyCare, the Social Security Administration or with your local county welfare agency (CWA). You must renew each year to keep your insurance. 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.
- 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 insurance before your termination date to continue to receive your medical benefits. If you do not, you could lose both your FFS health insurance 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, call your caseworker and inform him or her 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.

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. You will be automatically re-enrolled in UnitedHealthcare if you lost your eligibility for 2 months or less. The CWA office will let you know when you will re-join 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 77).
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.

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.

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 complaint and 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 Stature 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** — a problem that you have with UnitedHealthcare or one of our providers that can be solved within 5 business days.

**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.

**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.

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 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 problem that you have with UnitedHealthcare or one of our providers that can’t be solved within five (5) business days.

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 persons and for babies during the first two years that protect them from certain diseases.

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

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 Abuse benefit), Home and Community Based Services (HCBS) and institutionalization for long-term care in a nursing facility or special care nursing facility.
Other Plan Details

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 impairments 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.

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.

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 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 give you a referral on prescription pad or letterhead paper and may even help you make your first appointment.

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 MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED.
IT SAYS HOW YOU CAN GET ACCESS TO THIS INFORMATION. READ IT CAREFULLY.

Effective January 1, 2016.
We must by law 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.

We must by law follow the terms of this notice.

“Health information” (or HI) in this notice means information related to your health or health care services that can be used to identify you. We have the right to change our privacy practices. If we change them, we will notify you by mail or e-mail, as permitted by law. If we maintain a website for your health plan, we will also post the new notice on myuhc.com/CommunityPlan. We have the right to make the changed notice apply to HI that we have now and to future information. We will follow the law and give you notice of a breach of your HI.

We collect and keep your HI so we can run our business. HI may be oral, written or electronic. We limit access to all types of your HI to our employees and service providers who manage your coverage and provide services. We have physical, electronic and procedural safeguards per federal standards to guard your HI.

How we use or share your information.
We must use and share your HI with:
- You or your legal representative.
- The Secretary of the Department of Health and Human Services.

We have the right to use and share your HI for certain purposes. This must be for your treatment, to pay for your care, and to run our business. For example, we may use and share your HI:
- For Payment. We may use or share your HI to process premium payments and claims. This also may include coordinating benefits. For example, we may tell a doctor if you are eligible for coverage and how much of the bill may be covered.
- For Treatment or Managing Care. We may share your HI with providers to help them give you care.
- For Health Care Operations Related to Your Care. We may suggest a disease management or wellness program. We may study data to see how we can 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 plan sponsor. We may give them other HI if they agree to limit its use as required by federal law.

For Underwriting Purposes. We may use your HI to make underwriting decisions, but we will not use your genetic HI for underwriting purposes.

For Reminders on Benefits or Care. We may use your HI to send you information on your health benefits or care and doctor’s appointment reminders.

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. This may happen if you are unable to agree or object. Examples are an emergency or when you agree or fail to object when asked. If you are not able to object, we will use our best judgment. If you pass away, we may share HI with family members or friends who helped with your care prior to your death unless doing so would go against wishes that you shared with us before your death.

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, as allowed by law.

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.

For Correctional Institutions or Law Enforcement. For persons in custody: (1) To give health care; (2) To protect your health and the health of others; (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 Plan Details

- **Other Restrictions.** Federal and state laws may limit the use and sharing of highly confidential HI. This may include state laws on:
  1. HIV/AIDS
  2. Mental health
  3. Genetic tests
  4. Alcohol and drug abuse
  5. Sexually transmitted diseases and reproductive health
  6. Child or adult abuse or neglect or sexual assault

If stricter laws apply, we aim to meet those laws. The attached “Federal and State Amendments” document describes those laws in more detail.

Except as stated in this notice, we use your HI only with your written consent. This includes getting your written consent to share psychotherapy notes about you, to sell your HI to other people, or to use your HI in certain promotional mailings. If you allow us to share your HI, we do not promise that the person who gets it will not share it. You may take back your consent, unless we have acted on it. To find out how, call the phone number on your ID card.

**Your rights.**

You have a right:

- **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 involved in your care or payment for it. 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 that we use to make decisions about you. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you will have the right to ask for an electronic copy to be sent to you. You can ask to 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 wedeny 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: (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 require us to track.
• To get a paper copy of this notice. You may ask for a copy at any time. Even if you agreed to get this notice electronically, you have a right to a paper copy. If we maintain a website for your health plan, you may also get a copy at our website: myuhc.com/CommunityPlan.

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 1-800-941-4647 or TTY: 711.
• To Submit a Written Request. Mail to:
  UnitedHealthcare Government Programs 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.

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

Effective January 1, 2016.
We protect your "personal financial information" ("FI"). This means non-health information about someone with health care coverage or someone applying for coverage. It is information that identifies the person and is generally not public.

Information we collect.
We get FI about you from:
  • Applications or forms. This may be name, address, age and social security number.
  • Your transactions with us or others. This may be premium payment data.

Sharing of FI.
We do not share FI about our members or former members, except as required or permitted by law.
To run our business, we may share FI without your consent to our affiliates. This is to tell them about your transactions, such as premium payment.

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To other companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To other companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and security.
We limit access to your FI to our employees and service providers who manage your coverage and provide services. We have physical, electronic and procedural safeguards per federal standards to guard your FI.

Questions about this notice.
If you have any 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 1-800-941-4647 or TTY: 711.


2 For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1 on this page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women’s and Children’s Health, LLC; AmeriChoice Health Services, Inc.; Connexions HCl, LLC; Dental Benefit Providers, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; 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 Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, 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 healthplans in states that provide exceptions.
UNITEDHEALTH GROUP HEALTH PLAN NOTICE OF PRIVACY PRACTICES:
FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2016.
The first part of this Notice (pages 90 – 94) says how we may use and share your health information (“HI”) under federal privacy rules. Other laws may limit these rights. The charts below:

1. Show the categories subject to stricter laws.
2. Give you a summary of when we can use and share your HI without your consent.

Your written consent, if needed, must meet the rules of the federal or state law that applies.

### SUMMARY OF FEDERAL LAWS

#### Alcohol and Drug Abuse Information

We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.

#### Genetic Information

We are not allowed to use genetic information for underwriting purposes.

### SUMMARY OF STATE LAWS

#### General Health Information

We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.

| HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions. | KY |
| You may be able to restrict certain electronic disclosures of health information. | NC, NV |
| We are not allowed to use health information for certain purposes. | CA, IA |
| We will not use and/or disclosure information regarding certain public assistance programs except for certain purposes | KY, MO, NJ, SD |
| We must comply with additional restrictions prior to using or disclosing your health information for certain purposes. | KS |

| CA, NE, PR, RI, VT, WA, WI |
## Other Plan Details

<table>
<thead>
<tr>
<th>Prescriptions</th>
<th>ID, NH, NV</th>
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<tbody>
<tr>
<td>We are allowed to disclose prescription-related information only</td>
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<td>(1) under certain limited circumstances, and/or</td>
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<tr>
<td>(2) to specific recipients.</td>
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<tr>
<th>Communicable Diseases</th>
<th>AZ, IN, KS, MI, NV, OK</th>
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<tbody>
<tr>
<td>We are allowed to disclose communicable disease information only</td>
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<tr>
<td>(1) under certain limited circumstances, and/or</td>
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<tr>
<td>(2) to specific recipients.</td>
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<thead>
<tr>
<th>Sexually Transmitted Diseases and Reproductive Health</th>
<th>CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY</th>
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<tbody>
<tr>
<td>We are allowed to disclose sexually transmitted disease and/or reproductive health information only</td>
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<tr>
<td>(1) under certain limited circumstances and/or</td>
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<tr>
<td>(2) to specific recipients.</td>
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<thead>
<tr>
<th>Alcohol and Drug Abuse</th>
<th>AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI</th>
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<tbody>
<tr>
<td>We are allowed to use and disclose alcohol and drug abuse information</td>
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<tr>
<td>(1) under certain limited circumstances, and/or disclose only</td>
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<tr>
<td>(2) to specific recipients.</td>
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<tr>
<td>Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.</td>
<td>WA</td>
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<tr>
<th>Genetic Information</th>
<th>CA, CO, KS, KY, LA, NY, RI, TN, WY</th>
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<tr>
<td>We are not allowed to disclose genetic information without your written consent.</td>
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<tr>
<td>We are allowed to disclose genetic information only</td>
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<tr>
<td>(1) under certain limited circumstances and/or</td>
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<td>(2) to specific recipients.</td>
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<tr>
<td>Restrictions apply to</td>
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<tr>
<td>(1) the use, and/or</td>
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<tr>
<td>(2) the retention of genetic information.</td>
<td>FL, GA, IA, LA, MD, NM, OH, UT, VA, VT</td>
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</tbody>
</table>
### HIV/AIDS

We are allowed to disclose HIV/AIDS-related information only
(1) under certain limited circumstances and/or
(2) to specific recipients.

- AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY

Certain restrictions apply to oral disclosures of HIV/AIDS-related information.

- CT, FL

We will collect certain HIV/AIDS-related information only with your written consent.

- OR

### Mental Health

We are allowed to disclose mental health information only
(1) under certain limited circumstances and/or
(2) to specific recipients.

- CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI

Disclosures may be restricted by the individual who is the subject of the information.

- WA

Certain restrictions apply to oral disclosures of mental health information.

- CT

Certain restrictions apply to the use of mental health information.

- ME

### Child or Adult Abuse

We are allowed to use and disclose child and/or adult abuse information only
(1) under certain limited circumstances, and/or disclose only
(2) to specific recipients.

- AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI
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.