Hawai‘i

Connecting you to better health

QUEST Integration Member Handbook

Serving the islands of: Hawai‘i, Kaua‘i, Lana‘i, Maui, Moloka‘i and O‘ahu

United Healthcare Community Plan

CSHI23MD0116823_000

Important telephone numbers

UnitedHealthcare Community Plan QUEST Integration Member Services
(7:45 a.m.–4:30 p.m. HST, Monday–Friday) . . . . . toll-free **1-888-980-8728**
TTY users **711**

24/7 NurseLine (to chat with a nurse)
(available 24 hours a day, 7 days a week) . . . . . toll-free **1-888-980-8728**
TTY users **711**

UHCDoctorChat.com (to video chat with a doctor)
(available 24 hours a day, 7 days a week) . . . . . toll-free **1-888-980-8728**
TTY users **711**

Hāpai Mālama (for mothers-to-be)
(7:45 a.m.–4:30 p.m. HST, Monday–Friday) . . . . . toll-free **1-888-980-8728**
TTY users **711**
Fax . . . . . toll-free **1-800-267-8328**

Visit us in person
Our offices are open from 7:45 a.m.–4:30 p.m. HST, Monday–Friday.

Main office			
O‘ahu	1132 Bishop Street, Suite 400	Honolulu, HI 96813	888-980-8728
Neighbor Islands			
Hilo	45 Mohouli Street, Suite 204	Hilo, HI 96720	888-980-8728
Maui	340 Hana Highway, Suite B	Kahului, HI 96732	888-980-8728

Contact us via email

Contact us via email any time at: **communityplanhi@uhc.com**. If you contact us by email, we will reply or respond to you via the same email message unless you tell us to call you on the telephone or write to you at your mailing address. When we reply to you via email, we will use a secure delivery method to protect your information and privacy. You may also contact us via email through our member portal by signing on at **myuhc.com/CommunityPlan**, and selecting the HELP button at the top.

Contact us by mail

UnitedHealthcare Community Plan
1132 Bishop St., Suite 400, Honolulu, HI 96813

Website

myuhc.com/CommunityPlan

UnitedHealthcare Community Plan complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat people differently because of:

- Race
- Disability
- Age
- National Origin
- Color
- Sex/gender (expression or identity)

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

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

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

- Qualified interpreters
- Information written in other languages

If you need these services, contact us toll-free at **1-888-980-8728**, TTY **711**.

If you believe that UnitedHealthcare Community Plan has failed to provide these services or has discriminated in any way, you can file a grievance with:

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

Email: **UHC_Civil_Rights@uhc.com**

You can also file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

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

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

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

(English) Do you need help in another language? We will get you a free interpreter. Call **1-888-980-8728** to tell us which language you speak. (TTY: **711**).
(Simplified Chinese) 您需要其他语言吗？如果需要，请致电 **1-888-980-8728**，我们会提供免费翻译服务 (TTY: **711**).
(French) Avez-vous besoin d'aide dans une autre langue? Nous pouvons vous fournir gratuitement des services d'interprète. Appelez le **1-888-980-8728** pour nous indiquer quelle langue vous parlez. (TTY : **711**).
(German) Brauchen Sie Hilfe in einer anderen Sprache? Wir koennen Ihnen gern einen kostenlosen Dolmetscher besorgen. Bitte rufen Sie uns an unter **1-888-980-8728** und sagen Sie uns Bescheid, welche Sprache Sie sprechen. (TTY: **711**).
(Hawaiian) Makemake ʻoe i kōkua i pili kekahi ʻōlelo o nā ʻāina ʻē? E kiʻi nō mākou i mea unuhi manuahi nou. E kelepona i ka helu **1-888-980-8728** no ka haʻi ʻana mai iā mākou i ka ʻōlelo āu e ʻōlelo ai. (TTY: **711**).
(Ilocano) Masapulyo kadi ti tulong iti sabali a pagsasao? Ikkandakayo iti libre nga paraipatarus. Awaganyo ti **1-888-980-8728** tapno ibagayo kadakami no ania ti pagsasao nga ar-aramatenyo. (TTY: **711**).
(Japanese) 貴方は、他の言語に、助けを必要としていますか？私たちは、貴方のために、無料で通訳を用意できます。電話番号の、**1-888-980-8728** に、電話して、私たちに貴方の話されている言語を申し出てください。(TTY: **711**).
(Korean) 다른언어로 도움이 필요하십니까? 저희가 무료로 통역을 제공합니다. **1-888-980-8728** 로 전화해서 사용하는 언어를 알려주십시요 (TTY: **711**).
(Traditional Chinese) 您需要其它語言嗎？如有需要，請致電 **1-888-980-8728**，我們會提供免費翻譯服務 (TTY: **711**)。
(Marshallese) Kwōj aikuj ke jipañ kōn juon bar kajin? Kōm naaj lewaj juon aṃ ri-ukok eo ejjeḷọk wōṇean. Kūrtok **1-888-980-8728** im kowaḷọk ñan kōm kōn kajin ta eo kwō meḷeḷe im kōnono kake. (TTY **711**).
(Samoan) E te mana'o mia se fesosoani i se isi gagana? Matou te fesosoani e ave atu fua se faaliliu upu mo oe. Vili mai i le numera lea **1-888-980-8728** pea e mana'o mia se fesosoani mo se faaliliu upu. (TTY: **711**).
(Spanish) ¿Necesita ayuda en otro idioma? Nosotros le ayudaremos a conseguir un intérprete gratuito. Llame al **1-888-980-8728** y díganos qué idioma habla. (TTY: **711**).
(Tagalog) Kailangan ba ninyo ng tulong sa ibang lengguwahe? Ikukuha namin kayo ng libreng tagasalin. Tumawag sa **1-888-980-8728** para sabihin kung anong lengguwahe ang nais ninyong gamitin (TTY: **711**)
(Tongan) ʻOku ke fiemaʻu tokoni ʻiha lea makehe? Te mau malava ʻo ʻoatu ha fakatonulea taʻetotongi. Telefoni ki he **1-888-980-8728** ʻo fakaha mai pe koe ha ʻae lea fakafonua ʻoku ke ngaueʻaki. (TTY: **711**).
(Vietnamese) Bạn có cần giúp đỡ bằng ngôn ngữ khác không? Chúng tôi sẽ yêu cầu một người thông dịch viên miễn phí cho bạn. Gọi **1-888-980-8728** nói cho chúng tôi biết bạn dùng ngôn ngữ nào. (TTY: **711**).
(Visayan) Gakinahanglan ka ba ug tabang sa imong pinulongan? Amo kang mahatagan ug libre nga maghuhubad. Tawag sa **1-888-980-8728** aron magpahibalo kung unsa ang imong sinulti-han. (TTY: **711**).

Get connected online in 3 easy steps

Register today to use the secure member website. It gives you access to your important health plan information — anytime you need it.

1. Go to **myuhc.com/CommunityPlan**.
2. Click the "Register Now" button.
3. Enter the following information:
   a) First name
   b) Last name
   c) Date of birth
4. Enter your member ID information that is listed on the front of your UnitedHealthcare Community Plan QUEST Integration member ID card.
5. Enter the Group Number that is listed on the front of your UnitedHealthcare Community Plan QUEST Integration ID card.

You can view or find the following information and more at myuhc.com/CommunityPlan:

- Information about us and contact information
- View your Member Handbook
- View and print your member ID card
- Chat with a live nurse at anytime
- Stay informed about COVID-19 and learn how to stay healthy
- Find a provider in our Provider Network Directory
- Change your Primary Care Provider (PCP)
- See your covered benefits and services
- Services that we provide
- Find pharmacies near you
- Find covered medications
- View your prescriptions and or manage home delivery
- View Explanation of Benefits (EOB) or claims information about the health care services you received
- See Prior Authorization requests and information
- How to contact your Health Coordinator
- View your Health Action Plan, if you have one
- Find a list of tests and screenings that we recommend for you
- Send us a secure email to make changes such as change in your address, telephone number or other information about you
- Send us a secure email to send a message to your Health Coordinator or to request to change your Health Coordinator
- View our Advance Directives Policy
- View our Health and Wellness resources

Want to access your information from a mobile app?

Download the UnitedHealthcare Health4Me app® in the App Store or Google Play. It offers many of the same features as the secure member website — and you use the same username and password. It's great for when you're on the go.

Scan to download the UnitedHealthcare® app

Your health care providers

My primary care provider's name: _____

My primary care provider's phone number: _____

Other doctor's name: _____

Other doctor's phone number: _____

Pharmacy: _____ Phone: _____

If you need help with finding a provider or have questions about your health plan, please call us. Our Member Services in Hawai'i can be reached toll-free at 1-888-980-8728 (TTY users 711), 7:45 a.m.–4:30 p.m. HST, Monday–Friday.

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New member checklist

Welcome to the community!

We are happy to have you as a new member of UnitedHealthcare Community Plan. Our first priority is your health. All new members are sent a Member Enrollment Packet within ten (10) days of being enrolled with UnitedHealthcare Community Plan. Families with more than one (1) Member living in the same household (including Members under the age of nineteen (19)) will be sent one (1) enrollment packet. Your Member ID card is mailed out separately from the member enrollment packet(s). The Member Enrollment Packet includes the following:

- Welcome letter (enrollment confirmation)
- UnitedHealthcare Community Plan QUEST Integration Member ID card may be mailed separately
- Getting Started Guide
- A Health Risk Assessment (HRA) survey
- A flyer or handout that will provide the following:
  - An explanation of the role of the Primary Care Provider (PCP) and procedures to be followed to obtain needed services
- Health Plan assistance in selecting a PCP and how you can receive assistance
- Information on when the Health Plan will assign you a PCP if you do not select a PCP within ten (10) days
- PCP selection form
- An explanation of your rights, including those related to grievance and appeals procedures
- A description of your responsibilities that includes information or changes that you must provide or report to the Health Plan and the Department of Human Services (DHS). Changes may include but are not limited to:
  - Pregnancy
  - Marriage
  - Divorce
  - Birth or adoption of a child
  - Death of a spouse or child
  - Acceptance/loss of a job
  - Having other health insurance coverage in addition to your Medicaid coverage
  - Change in address, home or mobile/cell number or email address
- Information on how to obtain Advance Directives
- How to access assistance for other languages, such as Korean, Vietnamese, Chinese, Ilocano, etc.

Member Handbook

Your Member Handbook has all the information you need to get the most out of your new health plan including programs to keep you and your family healthy. The Member Handbook also gives you information that will help you get connected to our secured website so that you can view coverage and benefit information online, view or print your member ID card, view the Member Handbook online, Provider Directory information, Preferred Drug List (PDL) and other important resources and information. It also gives you important website links to the Provider Directory, Preferred Drug List (PDL), and other important documents and information. This Member Handbook is available on our website at **myuhc.com/CommunityPlan**. The Member Handbook is available in other languages. We can also provide you with a paper copy of this Member Handbook within five (5) business days upon request at no cost to you. Let us know how many paper copies you want for your household. Every year, we will send you the weblink information to the electronic form of the Member Handbook through either a post card, brochure, newsletter, or other forms of communication. The Member Handbook is reviewed and approved by the Department of Human Services (DHS). All changes made to the Member Handbook are submitted to the DHS for review and approval.

The following are a few items that you can do now to get you and your family on the path to good health.

Review member ID card

Your member ID card has the UnitedHealthcare Community Plan logo on it. You should have received a separate member ID card for each member of your family who is enrolled in our plan.

Take your member ID card with you when you go to the doctor or get a prescription. Keep this card with you at all times. This card is only for the person whose name is printed on the card. Never give your card to anyone else to use, not even other members of your family.

Confirm or choose Primary Care Provider (PCP)

Your member ID card may have the name of a doctor, provider, or clinic on it. If this is a provider or clinic you have seen in the past and you want to continue to see this provider, you don't need to do anything. This provider is your Primary Care Provider (PCP) so you should contact this provider first when you have a health concern as well as ongoing health needs.

If the provider's name on your card is not who you currently go to, or if your card reads "Please call to select a PCP," then please call Member Services toll-free at **1-888-980-8728** (TTY users **711**). We will help you select a primary care provider in your area. If you already have a PCP, be sure to tell us your PCP's name. If the PCP is in our network, you can continue seeing that PCP. If your PCP is not in our network, we will work with your PCP about joining our network or help you find an in-network PCP.

Complete Health Risk Assessment

As a new member you will soon receive a welcome call from us. We will call to discuss all your benefits and make sure you have a primary care provider. During the welcome call, we will help you with completing a short survey so we can understand your health needs and better serve you. You can also complete the Health Risk Assessment survey that was sent to you in your new member enrollment packet and send it back to us. If you would like, you can call us toll-free at **1-888-980-8728** (TTY users **711**) at a time that works best for you, 7:45 a.m.–4:30 p.m. HST, Monday–Friday. You will receive a gift card as a thank you for completing the new member Welcome Call and Health Risk Assessment (HRA).

Schedule first appointment with your Primary Care Provider (PCP)

It is important to have a checkup with your PCP even if you do not feel sick. Make an appointment now to see your PCP. Refer to **pages 44** and **45** on the acceptable wait times to get a doctor's appointment.

Provide feedback about the Member Handbook

We are always looking for ways to help us improve how we communicate with our members and we welcome your feedback. We would like to hear your feedback on the following:

- Did the Member Handbook explain what services are covered?
- Was the Member Handbook easy to read?
- Was the information in the Member Handbook easy to understand?
- Was it easy for you to find the information that you were looking for?

You can provide feedback by calling Member Services toll-free at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m. HST, Monday–Friday, or at any time when you are speaking with Member Services.

Reminder for every member

Thank you for being a member of UnitedHealthcare Community Plan. This Member Handbook is available on our website at **myuhc.com/CommunityPlan**. We can also provide you with a paper form or copy of this Member Handbook within five (5) business days upon request at no cost to you. Review this checklist to make sure you and your family are continuing on the path to good health. Every year, we will send you the web-link information to the Member Handbook through either a post card, brochure, newsletter, or other forms of communication.

Schedule an appointment with your Primary Care Provider (PCP)

It is important to have a checkup every year with your PCP even if you don't feel sick. Make an appointment to see your PCP. If you signed up for our plan, you may have selected your own PCP. If you didn't, we chose one for you that you can change at any time. You can find your PCP information on your member ID card. To find a new PCP, visit **myuhc.com/CommunityPlan** or the UnitedHealthcare® app. You can search by your zip code and sort the results by distance to see providers near you. You can also call Member Services toll-free at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m. HST, Monday–Friday. We're happy to help you find a network PCP that works for you. Refer to **page 35** for additional information on changing your PCP.

What if I need care immediately?

If you have an emergency, go immediately to the Emergency Room (ER) at the nearest hospital. If you need help getting to the ER fast, call **911**. If you need care today but it is not an emergency, you have a few options: choose an Urgent Care Clinic (you do not need a prior authorization), or you can call your PCP for an urgent appointment or call NurseLine to speak to our nurses who are available anytime free of charge. If you must speak to a doctor immediately, you can go to **UHCDoctorChat.com** for a virtual visit. Please refer to **page 127** for a list of emergency facilities and **page 131** for a list of urgent care centers.

Confirm you have your QUEST Integration member ID card

If you cannot find your QUEST Integration member ID card and need a replacement QUEST Integration member ID card, please call Member Services toll-free at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m. HST, Monday–Friday.

Tell us if you changed your address, phone number or email address

If you have a new address, phone number, and/or email address, please call Member Services toll-free at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m. HST, Monday–Friday, or go to our website at: **myuhc.com/CommunityPlan**. Please note that while we will notify the State of the changes that you may share with us, you must also notify your Department of Human Services (DHS) case worker that your information has changed. You must report these changes to the DHS within ten (10) days of the change. The reason that you must also notify your DHS case worker of a change is because our system can only be updated with those changes when the DHS gives us updated information. It is extremely important for the DHS to have your most current physical and mailing address as well as your phone number and email, to ensure you receive notification of important information that may impact your Medicaid eligibility and coverage.

Renew and keep your QUEST Integration coverage

The Department of Human Services (DHS) will send you a letter with instructions on how to renew or keep your QUEST Integration coverage. Sometimes these letters are sent in a pink envelope or a white envelope. You must provide your DHS case worker with any requested information in order to complete their annual review to determine if your medical coverage will continue. If you do not provide the requested information by the deadline given by DHS, you may lose your Medicaid coverage all together. If you lose your Medicaid coverage you will need to reapply for coverage again. It is extremely important for you to respond to the DHS right away to keep your health plan coverage.

During an open enrollment or eligibility redetermination period, the DHS will provide you with a separate Medicaid Member Handbook or Booklet that will help you and your family make the most of your health coverage. The DHS Medicaid Member Handbook or Booklet includes information such as choosing a QUEST Integration plan, your QUEST Integration benefits, reporting changes to the DHS, reapplying for Medicaid (if you lose your Medicaid coverage), and more.

Disenrollment from QUEST Integration and/or the Medicaid Program

Only the Department of Human Services (DHS) can process your enrollment or disenrollment from the QUEST Integration or the Medicaid Program. If you want to disenroll or end your participation in the QUEST Integration or Medicaid program, please contact the DHS for assistance.

UnitedHealthcare has policies and procedures in place that outlines the disenrollment requirements and limitations as required by the DHS. Please contact Member Services if you need additional or specific information related to the DHS' disenrollment requirements and limitations.

What if I want to change health plans?

Below are examples of when you are allowed to change from one health plan to another health plan:

- During the annual plan change period
- One (1) plan change is allowed within the first ninety (90) days grace period of your enrollment with your current health plan regardless of the reason for the plan change
- If you missed the annual plan change due to a temporary loss of Medicaid eligibility
- Your PCP and/or other doctor(s) are not in your current health plan's provider network but are in another health plan's provider network
- Your current health plan has a waiting list for HCBS or "At Risk" services but another health plan does not have a waiting list for the necessary service(s)
- The DHS has imposed sanctions on your current health plan
- Your current health plan's contract with the DHS is terminated or is suspended
- Mutual agreement by your current health plan, the other health plan, and the DHS

You can also request a plan change at any time due to the following:

- Provisions in administrative rules, Federal and State statutes
- A legal action
- You relocated to a service area where your current health plan does not provide the service
- Change in foster placement if necessary for the best interest of the child
- The Health Plan's refusal, because of moral or religious objections, to cover the service that you may need (note that UnitedHealthcare provides all covered services required by the DHS)
- Related services that are normally performed at the same time are not available through your current health plan but are available through another health plan and your doctor determines that receiving the services separately may cause unnecessary risk to your health

Other reasons, include but not limited to:

- Lack of access to covered services
- Poor quality of care
- Not having direct access to women's health care specialists for breast cancer screening, pap smears, or pelvic exams
- Lack of access to specialists you need
- Your current provider(s) is no longer part of your current health plan's provider network

Tell us your opinion and ideas

You can always call Member Services toll-free at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m. HST, Monday–Friday to share your opinion and ideas. As a member, you can also join our Member Advisory Group (MAG) where you can share your opinion about your experience with our services and about the way these services are delivered to you. It is free to join MAG. You need to:

1. Let us know that you want to join MAG by calling Member Services at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m. HST, Monday–Friday. Member Services provides information about MAG and informs you when the next meeting will take place.
2. Attend the MAG meetings once you have joined.
3. The meetings will be held virtually on the internet, by telephone, or in person at our offices.
4. Tell us how we are doing. At each meeting, the MAG members discuss ways to improve our member experience or sometimes focus on a specific topic.

Getting started

Welcome to UnitedHealthcare Community Plan

Thank you for being a member with UnitedHealthcare Community Plan. QUEST Integration is a Medicaid managed care program from the Hawai‘i Department of Human Services (DHS). We provide health coverage for members who have Hawai‘i Medicaid. We are pleased to serve you. With UnitedHealthcare Community Plan, you will receive all your regular Medicaid benefits offered through the QUEST Integration program. Please see **page 108** for additional benefits or value-added services provided only through UnitedHealthcare Community Plan.

You have a choice of a personal health care provider who will make sure that you get all the care you need to stay healthy. This provider is also called your primary care provider (PCP). You should see your PCP for all your medical needs. Your PCP will evaluate, assess, and determine the type of services you may need to keep you healthy. Your PCP may want you to go to a specialist that treats health problems like an allergy or a heart concern. Please refer to **page 37** for more information about seeing another doctor or specialist.

There is a space on **page 6** of this Member Handbook to write down the names and phone numbers of your doctors.

Educational programs

UnitedHealthcare QUEST Integration provides education in various formats and settings. Education may be provided in a class setting, in individual or group sessions, the use of videotapes, online (i.e., Zoom or TEAMS meeting), written materials, and media campaigns. Education sessions and materials will be provided in a manner and format that is easy for you to understand.

Request for information

You can request a copy of the Member Handbook, Provider Directory, PCP Form, or any other information at any time at no cost to you and we will send you the information within five (5) business days. We can send the information by mail to your mailing address that we have on file. Or if you give us verbal or written permission to email you, we can email you the information you request. You can also see or print the information by visiting our website at: **myuhc.com/CommunityPlan**. Refer to **page 5** of this Member Handbook on how to register on **myuhc.com/CommunityPlan**. The information available through our website is in a format that is easy to access and understand. You can also visit our offices on the islands of Oahu and Maui or in Hilo. Please refer to **page 2** for the addresses to these office locations.

Peace of mind

UnitedHealthcare promotes an environment of diversity and inclusion in which differences are encouraged, recognized, and celebrated to empower our members to access and receive timely health care services.

Whenever you have questions, our Member Services department is available to you. We can answer your questions and help you get the care you need. You can call Member Services toll-free at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m. HST, Monday–Friday. There are people who can talk with you in English or other languages. If you need help in other languages or an interpreter, including sign language, please call Member Services.

If you call after these hours, your call will be answered by voicemail and a representative will call you back in one (1) business day. Our Member Services can help you with anything related to your health plan, for example, they can:

- Explain your health program, options, and choices
- Answer questions about how to get care when you need it
- Help you with any problems you have with your health care
- Help arrange a ride to and from your doctor's office or hospital when medical care is needed. Please see **page 140** for more information.
- Help arrange for an interpreter if you do not speak or understand English (at no cost to you)
- Help arrange for interpreter or sign language services if you are hard-of-hearing (at no cost to you)
- Help you read and understand this Member Handbook. We can provide you with a Member Handbook in Chinese (Traditional), Ilocano, Korean and Vietnamese if you need it. We can also provide the Member Handbook to you in large print, braille, or audio format.
- Help you with your PCP changes whenever you need a new PCP, for any reason
- Help you with filing a grievance or appeal, and assistance with filling out forms

Advocate4Me

What is Advocate4Me (A4Me)?

Advocate4Me connects you with caring and well-trained Advocates who will focus on your health care related needs and how to achieve them. A4Me is our operating model for our Member Services and at the same time, it's our culture. Advocates use technology that will provide them with member data across medical, behavioral, clinical and pharmacy which gives them a view of each person's health and health care interactions. This technology enables early identification of a person's health care support needs, enabling the Advocates to anticipate and respond to questions and concerns using individual preferences. Advocates will help with the following:

- Answer questions related to benefits
- Assist with locating providers
- Assist with scheduling appointments with providers
- Assist with transportation for medical appointments
- View gaps in care and assist with education
- Connect you with wellness, medical and behavioral health resources
- Follow-up or touch base with you to make sure all your questions have been answered

Call **1-888-980-8728** (TTY users **711**) to connect to an Advocate today.

What is managed care?

Managed care provides health care and related services in a coordinated way. The emphasis is on quality, access, service, and value. With managed care, you have a care team to help you. Your care team is UnitedHealthcare Community Plan, your PCP, other health care providers and, most importantly, **you**.

How do your providers get paid in managed care?

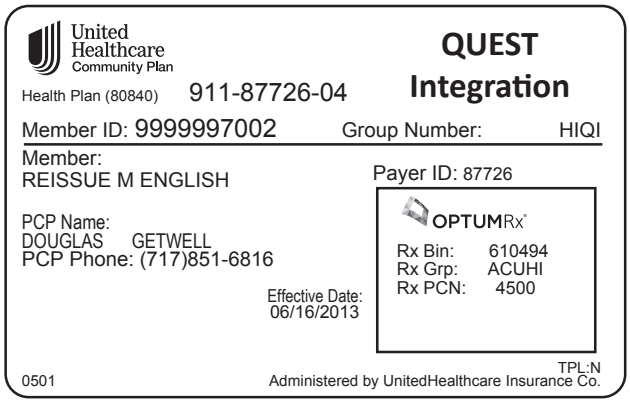
When you see your PCP or any other in-network provider, the provider will bill UnitedHealthcare Community Plan. You should never get a bill for any covered services or be asked to make a payment at a doctor's office. You will not lose your Medicaid benefits if you do not pay for non-covered services. Refer to **page 150** for additional information related to payment for services.

Your UnitedHealthcare Community Plan QUEST Integration member ID card

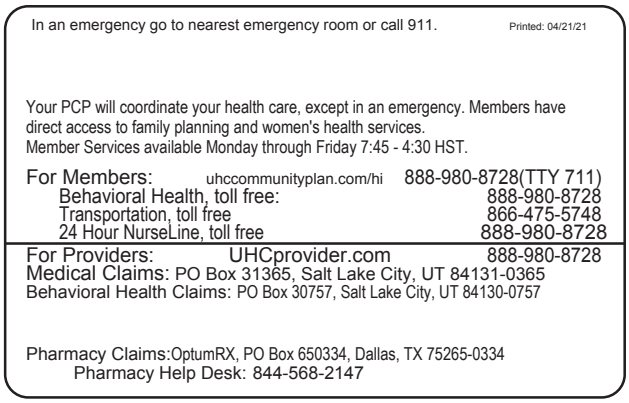
You should have received your QUEST Integration member ID card in the mail. Your QUEST Integration member ID Card is sent separately from your enrollment packet. Make sure the information is correct. If you have questions, call Member Services toll-free at **1-888-980-8728** (TTY users **711**). Every member of your family who has joined UnitedHealthcare Community Plan should have their own QUEST Integration member ID card. Keep your card with you at all times.

Take your QUEST Integration member ID card with you when you go to the doctor, the pharmacy, or any provider. Never give your QUEST Integration member ID card to anyone else to use. Call Member Services toll-free at **1-888-980-8728** (TTY users **711**) if you lose your QUEST Integration member ID card or need to correct some of the information on your QUEST Integration member ID card. We will send you a replacement or updated QUEST Integration member ID card within ten (10) days of the request or for any other reason that results in a change to your information including membership renewal with continuing eligibility.

Your UnitedHealthcare Community Plan QUEST Integration member ID card will look like this:



Front



Back

Language help

Your primary language may not be English. We can give the information in your preferred language. We can do this through written translation or oral interpretation. Let us know if you have a language preference. This will help us ensure that you get information in your preferred language.

If you have trouble hearing over the phone, the Telecommunications Relay Service (TRS) can help. This service allows individuals with hearing or speech disabilities to place and receive telephone calls. This service is free. Call **711**, give them the toll-free Member Services number **1-888-980-8728** (TTY users **711**), and they will connect you to us. You do not have to look for an interpreter on your own and you do not have to use a friend or family to help you with interpreting or translation services. We are here to help you.

We can give you member materials in a language and/or in a written format that is easier for you to understand. We have interpreters for you if your doctor does not speak your language. This is free when you speak to us or your doctors. If you do not speak English, call Member Services toll-free at **1-888-980-8728** (TTY users **711**). They will connect you with an interpreter.

We make all written information for Members available in languages that comply with Section 1557 of the Patient Protection and Affordable Care Act. If you need information in a language other than English (i.e., Ilocano, Vietnamese, Chinese (traditional), Korean, etc.), call Member Services. All written materials will be in font size that is at least a twelve (12) point font size. You can also get information in large print, braille, or audio tapes. We can send you the information in another language within seven (7) days of the request. If the request is received after normal business hours, we will send you the information within seven (7) days of the next business day following the request.

Examples of written materials include but are not limited to:

- Provider Directory
- Member Handbook
- Appeals and Grievance Notices
- Adverse Benefit Determination Notices
- Network Provider Termination Notices to members

The services and help listed above are available to current and potential members at no cost.

This Member Handbook and all member written materials, including educational and program materials, training plans and curricula and any changes to program information are submitted to the Department of Human Services (DHS) for review and approval prior to the distribution to members. UnitedHealthcare and its subcontractors and vendors only use member materials that have been approved by the DHS.

(English) Do you need help in another language? We will get you a free interpreter. Call **1-888-980-8728** to tell us which language you speak. (TTY: **711**).
(Simplified Chinese) 您需要其他语言吗？如果需要，请致电 **1-888-980-8728**，我们会提供免费翻译服务 (TTY: **711**).
(French) Avez-vous besoin d'aide dans une autre langue? Nous pouvons vous fournir gratuitement des services d'interprète. Appelez le **1-888-980-8728** pour nous indiquer quelle langue vous parlez. (TTY : **711**).
(German) Brauchen Sie Hilfe in einer anderen Sprache? Wir koennen Ihnen gern einen kostenlosen Dolmetscher besorgen. Bitte rufen Sie uns an unter **1-888-980-8728** und sagen Sie uns Bescheid, welche Sprache Sie sprechen. (TTY: **711**).
(Hawaiian) Makemake ʻoe i kōkua i pili kekahi ʻōlelo o nā ʻāina ʻē? E kiʻi nō mākou i mea unuhi manuahi nou. E kelepona i ka helu **1-888-980-8728** no ka haʻi ʻana mai iā mākou i ka ʻōlelo āu e ʻōlelo ai. (TTY: **711**).
(Ilocano) Masapulyo kadi ti tulong iti sabali a pagsasao? Ikkandakayo iti libre nga paraipatarus. Awaganyo ti **1-888-980-8728** tapno ibagayo kadakami no ania ti pagsasao nga ar-aramatenyo. (TTY: **711**).
(Japanese) 貴方は、他の言語に、助けを必要としていますか？私たちは、貴方のために、無料で通訳を用意できます。電話番号の、**1-888-980-8728** に、電話して、私たちに貴方の話されている言語を申し出てください。(TTY: **711**).
(Korean) 다른언어로 도움이 필요하십니까? 저희가 무료로 통역을 제공합니다. **1-888-980-8728** 로 전화해서 사용하는 언어를 알려주십시요 (TTY: **711**).
(Traditional Chinese) 您需要其它語言嗎？如有需要，請致電 **1-888-980-8728**，我們會提供免費翻譯服務 (TTY: **711**)。
(Marshallese) Kwōj aikuj ke jipañ kōn juon bar kajin? Kōm naaj lewaj juon aṃ ri-ukok eo ejjeḷọk wōṇean. Kūrtok **1-888-980-8728** im kowaḷọk ñan kōm kōn kajin ta eo kwō meḷeḷe im kōnono kake. (TTY **711**).
(Samoan) E te mana'o mia se fesosoani i se isi gagana? Matou te fesosoani e ave atu fua se faaliliu upu mo oe. Vili mai i le numera lea **1-888-980-8728** pea e mana'o mia se fesosoani mo se faaliliu upu. (TTY: **711**).
(Spanish) ¿Necesita ayuda en otro idioma? Nosotros le ayudaremos a conseguir un intérprete gratuito. Llame al **1-888-980-8728** y díganos qué idioma habla. (TTY: **711**).
(Tagalog) Kailangan ba ninyo ng tulong sa ibang lengguwahe? Ikukuha namin kayo ng libreng tagasalin. Tumawag sa **1-888-980-8728** para sabihin kung anong lengguwahe ang nais ninyong gamitin (TTY: **711**)
(Tongan) ʻOku ke fiemaʻu tokoni ʻiha lea makehe? Te mau malava ʻo ʻoatu ha fakatonulea taʻetotongi. Telefoni ki he **1-888-980-8728** ʻo fakaha mai pe koe ha ʻae lea fakafonua ʻoku ke ngaueʻaki. (TTY: **711**).
(Vietnamese) Bạn có cần giúp đỡ bằng ngôn ngữ khác không? Chúng tôi sẽ yêu cầu một người thông dịch viên miễn phí cho bạn. Gọi **1-888-980-8728** nói cho chúng tôi biết bạn dùng ngôn ngữ nào. (TTY: **711**).
(Visayan) Gakinahanglan ka ba ug tabang sa imong pinulongan? Amo kang mahatagan ug libre nga maghuhubad. Tawag sa **1-888-980-8728** aron magpahibalo kung unsa ang imong sinulti-han. (TTY: **711**).

Members with Medicare or other insurance coverage

Members with Medicare health insurance coverage

If you have both Medicare and QUEST Integration (Medicaid) health insurance plans, you have more than one insurance coverage. Your QUEST Integration benefits will not change your Medicare benefits. We are here to help coordinate your care and medical benefits with Medicare and QUEST Integration even if you have Medicare or QUEST Integration health insurance coverage with UnitedHealthcare, Original Medicare or another Medicare Advantage health plan.

For most services, your Medicare health insurance coverage will be first and your QUEST Integration (Medicaid) health insurance coverage will be last.

If you have Medicare, your Medicare Part D will cover most of your drugs. To learn about QUEST Integration drug coverage, refer to the **Pharmacy** section on **page 146** of this Member Handbook or call Member Services toll-free at **1-888-980-8728** (TTY users **711**) for assistance.

We will coordinate your health insurance benefits with original Medicare or the Medicare Advantage plan you have. We will provide QUEST Integration benefits that are not covered by Medicare. UnitedHealthcare also offers Medicare health insurance coverage and many members choose to use UnitedHealthcare as their health plan for both Medicare and QUEST Integration. For more information on how you can choose UnitedHealthcare for both your Medicare and QUEST Integration health insurance coverage, call Member Services at **1-888-980-8728** (TTY users **711**).

Members with Medicare health insurance coverage through UnitedHealthcare

If you have Medicare health insurance coverage through UnitedHealthcare you can look up your Medicare health insurance coverage and benefits information in your Evidence of Coverage (EOC) booklet that was sent to you. You can also view the drug list, find a doctor or pharmacy and other plan information online via the same websites provided.

If you have questions about health products/catalog, gym/fitness program, dentures and other services that are offered through our UnitedHealthcare Dual Complete® (PPO D-SNP) plan, please call our DSNP Call Center toll-free at 1-866-622-8054 (TTY users 711) for assistance.

Hours of operations are:

April–September:
8:00 a.m.–8:00 p.m.
Monday–Friday

October–March:
8:00 a.m.–8:00 p.m.
7 days a week

You can also visit our website at: **www.UHCCommunityplan.com/hi**.

Members with Medicare health insurance coverage through Original Medicare

If you have Medicare health insurance coverage through Original Medicare, you can use your current doctors and providers for Medicare services. If you have questions about your medical coverage and benefits through Original Medicare, look in your Medicare & You Handbook. You can also view it online at **https://www.medicare.gov** or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Members with Medicare health insurance coverage through another Medicare Advantage health plan

If you have Medicare health insurance coverage through another Medicare Advantage health plan, please read and follow what your Medicare Advantage health plan requires. If you have questions about your medical health insurance benefits or coverage through your Medicare Advantage health plan, there should be a telephone number on the back or front of your Medicare Advantage member ID card that you can call for assistance. If you are unable to locate the contact information, we can help you get connected with your Medicare Advantage health plan (just give us a call).

We will work with your Medicare doctor for the services you get through QUEST Integration. Tell us the name of your Medicare doctor. Let us know if you change doctors. We can help you pick a doctor if you do not have one. This doctor can provide and set up your QUEST Integration and Medicare services. Call our toll-free Member Services number at **1-888-980-8728** (TTY users **711**) if you need help choosing a doctor.

Members with medical health insurance coverage through a commercial plan

If you have other health insurance coverage from a commercial insurance health plan, such as through an employer, we will coordinate your health insurance benefits and care with your commercial insurance health plan. You must follow the rules of your commercial or other health insurance plan, such as staying within their provider network and getting authorizations. If you have questions about your medical health insurance benefits or coverage through your commercial or other insurance plan, there should be a telephone number on the back or front of your member ID card that you can call for assistance. If you are unable to locate the contact information, we can help you get connected with your commercial health insurance plan (just give us a call).

Please take note of some important information below:

- Your other health insurance coverage or benefits will be “first” and QUEST Integration will be “last”
- For some services, such as long-term care, QUEST Integration will be “first”
- Newborns, children, spouses, or partners may have other health care coverage
- Please notify us if you have coverage through another health plan or if you lose other coverage by calling our Member Services department

Bring your Medicare, Medicare Advantage plan, Commercial plan member ID card(s) and your UnitedHealthcare QUEST Integration member ID card on all visits to doctors, hospitals, pharmacies, and other care providers. This will help your doctor(s) determine which insurance coverage to bill first to ensure appropriate coordination of benefits.

Getting long-term services and supports

Members who need long-term services and supports

If you need long-term services and supports (LTSS) services, we will work with you, your family, providers, and caregivers to help identify the type of services that you may need. These services will help support you in your own home or another place such as a nursing facility or care home. If you are currently getting long-term services, we will work with you and your providers to make sure you have access to these services. If you, your doctor, family or caregiver thinks you need long-term care, please contact us.

To get long-term services and supports, we need to send a request to the Department of Human Services (DHS) that will include information about the services that you may need for their review. **The DHS determines who can get LTSS services.**

Once the DHS determines that you qualify for LTSS services, we will work with you, your family, providers, and caregivers to make sure you get the covered services that you need.

Our goal is to help members live in their home and in their community. This includes members who need long-term care. Our covered services in the home will help you. We want you to be in your home with your family. Your family and friends can also help you. Sometimes a care home or a nursing facility may be a better place for your long-term service needs. We will work with you to make the best choice.

Some members may not fully qualify for LTSS services. This could mean you are “at-risk” and may need long-term services sometime in the future. We can provide **some** covered services in your home to help you. If you, your doctor, or family thinks you need some support services in your home, please contact us. We will also contact you if we see information that tells us you may need some help in your home.

If you have Medicare, please note that Medicare does not cover LTSS services.

Transition of care

Our goal is to ensure that you receive appropriate and timely care during the transition period. We are here to help. This includes, but is not limited to the examples listed below:

- If you are a new member to the UnitedHealthcare QUEST Integration Heath Plan:
  - We will cover emergent services without a prior authorization
  - We will cover non-emergent medically necessary services without a prior authorization even if your PCP or doctor is not yet participating in our provider network at least the first forty-five (45) days or until your medical needs have been assessed or reassessed by the PCP or doctor who authorized a plan of care, even if your doctor is not part of our provider network
  - When appropriate, we will refer you to a doctor in our provider network
  - We will cover non-emergent medical services previously authorized by your former QUEST Integration health plan that you transitioned from at least forty-five (45) days or until your medical needs have been assessed or reassessed by the PCP or doctor who authorized a plan of care, even if your doctor is not part of our provider network
  - If you are a member with Special Health Care Needs (SHCN) and/or LTSS, we will provide continuation of services for at least ninety (90) days or until you have been provided an assessment by a Health Coordinator
  - If you are inpatient at a hospital when you become a member with us, your previous health plan will cover the hospital stay until your level of care changes or you are discharged from the hospital. We will work with you and your providers on services needed after your level of care changes and after you leave the hospital.

All other members (i.e., non SHCN/LTSS) will be provided continuation of other services for at least forty-five (45) days or until your medical needs have been assessed or reassessed by the PCP who has authorized a plan of care, even if your PCP is not part of our provider network.

In the event you are joining the UnitedHealthcare Community Plan during your second or third trimester of pregnancy and are receiving medically necessary prenatal services the day before enrollment, we will provide continued access to your prenatal care provider through the postpartum period, even if your doctor is not part of our provider network.

We will ensure that you receive medically necessary services when you are:

- Being admitted into a hospital or skilled nursing facility or other type of facility such as a rehabilitation hospital
- Being discharged from a hospital. If you enroll or transition to another QUEST Integration health plan during a hospital admission stay, we will continue to cover medically necessary services until you are discharged from the hospital or if there is a change in your level of care, whichever occurs first.
- Transitioning from the UnitedHealthcare QUEST Integration Health Plan to another QUEST Integration health plan or the Medicaid Fee-For-Service Program including the State of Hawaii Tissue and Transplant (SHOTT) Program or other programs
- Going into, during and when you are leaving the Community Care Services (CCS) program

We will work with your former PCP to ensure that your new PCP gets a copy of your medical records.

You can access online our Transition of Care Policy for additional information and details via **myuhc.com/CommunityPlan** or call Member Services at **1-888-980-8728** (TTY users **711**) for assistance.

Getting behavioral health services

Behavioral health services are for mental health conditions. It also includes addiction to drugs or alcohol.

What are my behavioral health benefits?

You can get help from us. When you feel very upset or if you do not know what to do when life is hard, call us toll-free at **1-888-980-8728** (TTY users **711**). There are people who can talk to you in English or other languages. Member Services can connect you to an interpreter. If you are speech or hearing impaired, call TTY **711. If it is a crisis, call 911 or go to an emergency room.**

We can help you find a provider for these services. We can help you with mental health and substance abuse issues. We can help you find the amount of care that you need depending on what your needs are. Call us toll-free at **1-888-980-8728** (TTY users **711**).

For adults with serious mental illness in crisis

Contact the 24-hour Crisis/Help ACCESS Line Crisis Line of Hawai‘i at 808-832-3100 on O‘ahu. The toll-free number for the neighbor islands is 1-800-753-6879. Ask about eligibility. This is the Department of Health (DOH). They cover some eligible mental health services. These may include crisis services, crisis outreach and more. Services are available on O‘ahu, Kaua‘i, Hawai‘i, Maui, Moloka‘i and Lāna‘i.

For children with emotional and behavioral issues (ages 3 through 20)

CAMHD gives behavioral health services for those eligible for Department of Health (DOH) help. CAMHD means Child and Adolescent Mental Health Division. They provide more intensive treatment. Call toll-free at 1-800-294-5282.

For all other children, the health plan covers eligible behavioral health services.

For adult members with Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI)

A program called Community Care Services (CCS) helps adult members with SMI or SPMI. This includes providing additional services to support adult members with SMI or SPMI. For more information, please see the Comprehensive Behavioral Health Services for Adults section on **page 112**.

There are many types of programs that treat substance abuse. These programs try to break the cycle of addiction. They monitor the member's mental status. They help the member see a psychiatrist if psychotropic drugs are needed. They recommend a psychologist for depression or anxiety. Once stable, a member may be moved to an Intensive Outpatient Program (IOP). This usually includes narcotics abuse/alcohol abuse meetings, and therapy sessions. It helps identify triggers and prevent relapse.

We can help you find a provider for behavioral health. We can help you with mental health and substance abuse. Call us toll-free at **1-888-980-8728** (TTY users **711**).

What other behavioral health help can I get?

We also have Behavioral Health Field Care Advocates and a Peer Specialist who can help you. These workers will meet you in the community or over the phone to find out what other services can help with your behavioral health needs. They can connect you with other programs in the community that can help you live your healthiest life.

How do Behavioral Health Field Care Advocates or a Peer Specialist help?

They can help identify your strengths and needs and find support for the things you need. If you need help finding a counselor or doctor, they can help you find one. If you don't have food or a place to live, they can connect you with help. If you are having mental health issues or use drugs or alcohol, or if you are feeling stressed and don't know what kind of help you need, they can talk with you to help you figure things out.

How can I connect with a Behavioral Health Field Advocate or Peer Specialist?

You can call us toll-free at **1-888-980-8728** (TTY users **711**) and ask to be referred to a Behavioral Health Field Advocate. Someone will call you back to get started. If you have a Health Coordinator, you can also ask them to refer you to a Behavioral Health Field Care Advocate.

Health Coordination

Our Health Coordinators bring together everyone involved in your care. This includes your doctors and other providers and helpers that support you. This keeps everyone informed and makes sure that you get the right kind of help depending on what you need. Your doctors and other providers will collaborate or discuss the types of programs or services, including the amount of care that you may need. Care Coordination also includes referrals for services that are covered only through the Department of Health, Child and Adolescent Mental Health Division (CAMHD), the Community Care Services (CCS), Department of Education, Women, Infants and Children (WIC) program, State of Hawai‘i Organ and Tissue Transplant (SHOTT) program, etc.

Our Health Coordinators review, plan, and help you meet your health needs and goals. Your Health Coordinator, if you have one, is your main contact for your QUEST Integration plan.

A Health Coordinator looks at your physical and behavioral health needs. He or she works with you and your family to get the services you need. Your Health Coordinator can also help you with other services and resources. This includes help with food and shelter, coordinating services with Medicare, other Department of Human Services (DHS) and Department of Health (DOH) programs if they are available and right for your care.

Your Health Coordinator sees you as a whole person, not just as someone with Medicaid coverage. Talk to your Health Coordinator if you think you need help in your home with cleaning, cooking, shopping, and running errands. Your Health Coordinator will work with you to complete the necessary assessment to evaluate and determine the type of services you may need and/or may be eligible for.

How will I know if I have a Health Coordinator?

You will be assigned to a Health Coordinator if your health risk assessment (HRA) tells us you might need help with your health. Or, if you feel you need help, you can ask for a Health Coordinator.

Who is my Health Coordinator?

We will choose your Health Coordinator. Your Health Coordinator will contact you by phone. If your Health Coordinator is unable to reach you, you will get a letter with the contact information for your Health Coordinator.

When will I meet my Health Coordinator?

Your Health Coordinator will meet you for an evaluation after you join UnitedHealthcare Community Plan. He or she will contact you once a quarter (every three (3) months) and as needed by telephone or in person depending on your need. If you are residing in a nursing facility, your Health Coordinator will contact you every six (6) months and as needed.

How can I contact my Health Coordinator?

You can contact your Health Coordinator by calling Member Services toll-free **1-888-980-8728** (TTY users **711**). You can contact your Health Coordinator as often as you need to.

What if I want a new Health Coordinator?

If you want to change Health Coordinators, call Member Services toll-free at **1-888-980-8728** (TTY users **711**). We can get you a new one in five business days. In some cases, UnitedHealthcare Community Plan will need to assign you to a new Health Coordinator. We will let you know who your Health Coordinator is either through a telephone call, in person or by mail.

What if I no longer want to receive Health Coordination?

You have the option to opt out of Health Coordination at any time. You can call Member Services toll-free at **1-888-980-8728** (TTY users **711**) to request to opt out of Health Coordination. You can also let your current Health Coordinator (if assigned one) know that you no longer need health coordination.

Not all members will have a Health Coordinator. Health Coordination is for QUEST Integration members with special health care needs (SHCN), Expanded Health Care Needs (EHCN), and members who may need Long-Term Services and Support (LTSS) or Community Integration Services (CIS).

Special Health Care Needs (SHCN)

SHCN members are those who have chronic physical, behavioral, or emotional conditions that require health related services of a type or amount that is beyond what is usually required by someone their age.

SHCN for children

A child with special health care needs is a child under twenty-one (21) years of age who has chronic physical, behavioral, developmental, or emotional conditions that require services beyond what is required of another child their age. Examples of children with special health care needs are those with chronic medical or behavioral health conditions, children who become pregnant, children with frequent visits to the hospital or emergency room or children with social conditions such as homelessness or who have experienced traumatic events.

SHCN for adults

An adult with special health care needs is someone who is twenty-one (21) years old or older who has chronic physical, behavioral, emotional or social conditions that require services of a type and amount beyond what is generally required of someone their age. Examples of adults with special health care needs are women with high risk pregnancies, adults with chronic medical conditions such as asthma, diabetes or chronic lung diseases, adults with frequent hospital or emergency room visits, adults with drug or alcohol problems, or adults with social conditions such as homelessness.

Expanded Health Care Needs (EHCN)

Services for members that are at risk of developing a chronic health condition such as a Serious Mental Illness (SMI), Substance Use disorder (SUD), asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), congestive heart failure (CHF), diabetes, obesity, chronic renal disease, chronic liver disease, and members receiving palliative care.

Long-Term Services and Supports (LTSS)

Services provided in an inpatient medical facility for members receiving nursing facility level of care or those residing in a nursing facility. These facilities include assisted living facilities, expanded adult care homes, community care foster family homes, nursing facilities, and sub-acute units. Some LTSS services may also be available for members who are not in a nursing facility level of care (NFLOC), but are considered "at-risk" of being in a NFLOC if they do not receive additional help at home or in their home.

Community Integration Services (CIS)

Pre-tenancy supports and tenancy sustaining services that support individuals to be prepared and successful tenants in housing that is owned, rented, or leased to the individual. Pre-tenancy supports help to identify the individual's needs and preferences, assist in the housing search process, and help to arrange details of the move. Tenancy sustaining services help with independent living sustainability that includes tenant/landlord education, and tenant coaching and assistance with community integration and inclusion to help develop natural support networks.

Going Home Plus (GHP) and institutional relocation service

Services to help Members that are in a hospital, psychiatric residential treatment facilities, prisons, nursing home or other long-term care facilities to successfully transition or move out and receive services to live independently in their own homes and communities. These services are available to youths with mental health conditions and those that are elderly or have physical, intellectual and development disabilities.

How to get health care services

Choosing a Primary Care Provider

Your primary care provider is called a PCP. Each member of UnitedHealthcare Community Plan must pick a PCP from our provider network or we can select one for you.

Your PCP office is your medical home. Your PCP is your personal doctor that will oversee your primary care services. Your PCP will help you get services from a specialist or other health care services that you may need. You pick a PCP for you and any family member in our plan. You may pick a different PCP for each family member. All providers in the UnitedHealthcare Community Plan provider network have agreed to take care of our members. Our provider directory will tell you if a provider is not accepting new members.

You can choose a PCP that is a family medicine doctor or general practitioner, internal medicine, pediatrician, obstetrician/gynecologist, geriatrician, physician's assistant, or nurse practitioner who is licensed to write prescriptions or a clinic.

If you have complex health care needs, a specialist can be your PCP. A specialist doctor is someone such as a Cardiologist, Neurosurgeon, Gastroenterologist, etc. If you know of a specialist who can be your PCP, call Member Services toll-free at **1-888-980-8728** (TTY users **711**) and give them the name of your specialist doctor. We will call your doctor's office to confirm that they will be your PCP. We will document this information in our system. We can also help you find a specialist doctor.

Some PCPs are part of large group practices or Federally Qualified Health Centers (FQHCs). Others may be smaller, independent practices. The important thing is to pick a PCP you feel comfortable with. Once you have chosen a PCP, you should see him or her for all of your medical needs. They will get to know you and your family. They will understand your background and keep your medical records.

There are many things to think about when choosing a PCP. You may want your PCP to be close to your home, your children's school or a bus route. All of our providers have met our high standards for quality care.

You can use our provider directory to find a PCP. It lists the providers' names, office locations, telephone numbers, languages spoken in the office, board certification, gender, hospital or group affiliation, website (if available), wheelchair accessibility and if the provider is taking new patients. You can also find a list online at **myuhc.com/CommunityPlan**. You can also call Member Services toll-free at **1-888-980-8728** (TTY users **711**). Please refer to the **Provider Directory** section on **page 36** for additional information.

If you do not choose a primary care provider within 10 days of receiving your new member welcome kit, we will pick one for you. We will select a PCP in your area who is accepting new patients. We will mail you a new member ID card with your PCP name and phone number. You can change your PCP at any time for any reason by calling Member Services. You can also change your PCP online at **myuhc.com/CommunityPlan**.

Some PCP offices will have nurse practitioners, nurse midwives and physician assistants to help with your health care needs. They provide care with the help of your PCP.

Choosing a provider for pregnancy

All pregnant health plan members are eligible for prenatal care (pregnancy checkups) starting on your enrollment date with UnitedHealthcare QUEST Integration Plan. As a new member, you should choose an OB/GYN provider in our provider network. Your OB/GYN provider can also be your primary care provider for other medical health needs. If you join UnitedHealthcare Community Plan in your second or third trimester of pregnancy, and you are already receiving prenatal services, you may stay with your current OB/GYN even if they are not in our provider network, through delivery and postpartum (after-delivery) services.

If you are pregnant, you may be eligible for additional benefits and services through our Hāpai Mālama pregnancy program. For additional information, or to sign up, call Member Services toll-free at **1-888-980-8728** (TTY users **711**) and ask for Hāpai Mālama. See **page 121** for additional information about our Hāpai Mālama program.

Rural exceptions

In areas in which there is only one QUEST Integration health plan, members have the freedom to:

- Choose from at least two (2) PCPs
- Obtain services from any other provider under any of the following circumstances:
  - The service or type of provider (in terms of training, experience, and specialty) is not available within the health plan's provider network;
  - The provider is not part of the health plan's provider network but is the main source of a service to the member. We will work with the provider to participate in our provider network. If the provider chooses not to join our provider network, or does not meet the necessary qualifications to be part of the provider network, we will transition the member to an in-network provider within sixty (60) days. If the provider is not appropriately licensed or is sanctioned, we will transition the member to another provider immediately;
  - The only provider in-network and available to the member does not, because of moral or religious objections, provide the services the member seeks, or all related services are not available;
  - The member's PCP determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all of the related services are available within the health plan's provider network; and
  - The DHS determines that other circumstances warrant out-of-network treatment.

Members with Medicare or other health insurance coverage

If you have a primary care provider through Medicare or other insurance, you do not have to pick a different primary care provider from our list of in-network providers. We will work with your current primary care provider to set up your QUEST Integration services. Call Member Services at **1-888-980-8728** (TTY users **711**) with the name of your current primary care provider so that we can update our system with that information.

Changing your PCP

You can change your PCP any time at **myuhc.com/CommunityPlan** or with the UnitedHealthcare app. To see providers near you, search by your ZIP code and sort the results by distance. You can also call Member Services at **1-888-980-8728** (TTY users **711**) for assistance. You can also change your PCP online at **myuhc.com/CommunityPlan**.

We're happy to help you find a network PCP that works for you. When deciding on a PCP, you may want to select one who:

- You have seen before
- Understands your health history
- Is taking new patients
- Can provide care in your language
- Is easy to get to

During your first month of membership, your PCP change will be effective the same day you request it. After your first month of membership, the day your PCP change is effective depends on when you request it. If you request a PCP change within the first 25 days of the month, your PCP change is effective on the first day of the next month. If you make a PCP change request during the last 5 days of the month, the change will take effect the first day of the second month.

For example:

- If you request a PCP change on April 15, the change takes effect May 1
- If you request a PCP change on April 29, the change takes effect June 1
- Immediate need — If you request a PCP change due to special circumstances (for example: a child that is under the guardian of the Foster Care/Child Welfare Services), the change will be made immediately

Provider Directory

How do I get a list of in-network providers?

The doctors and other people and places who give health care for our QUEST Integration members are called the Provider Network. All of these are listed in a Provider Directory. You can find the list online at **myuhc.com/CommunityPlan**, or the UnitedHealthcare app. The information in our provider directory or provider list that is on our website is updated, at least monthly. You can also call us toll-free at **1-888-980-8728** (TTY users **711**) to get a list or paper copy at no cost. Every year, we will send you the most current web-link information to our Provider Directory through a post card, brochure, newsletter, or other form of communication.

UnitedHealthcare Community Plan QUEST Integration members must go to the doctors on this list to ensure covered services are covered or paid. Direct access to women health services and during transition of care, such as pregnant women in their second or third trimester the day before they are enrolled with UnitedHealthcare Community Plan that are already receiving prenatal services from an out-of-network OB/GYN is allowed. These members may continue care from an out-of-network provider through delivery and postpartum (after delivery) services.

Our provider directory includes information about our physicians, including specialists, hospitals, pharmacies, behavioral health providers and LTSS providers. Any change(s) related to a provider's information are updated within 30 calendar days after we receive the update from the provider. You can use the online provider directory search tool called "Find a Provider" to help you search providers using a variety of filters or options such as the provider's name, specialty, ZIP code, service area, etc.

Our provider directory is updated at least monthly and includes the following information:

- Provider's name and any group affiliation
- Address(es) and location(s)
- Telephone number(s)
- Website uniform resource locator (URL), if available
- Specialties
- Board Certification (professional qualifications)
- If the provider is accepting new patients
- Cultural and linguistic capabilities, languages spoken by the office (including American Sign Language) and whether the provider has completed cultural competency training
- Accessibility accommodations to the provider's office or facility

You can find the most up-to-date provider directory online at **https://connect.werally.com/medicalProvider/root** or the UnitedHealthcare app. If you need help with accessing the provider directory or provider list from our website, or want more information about a provider, or want a printed copy of the provider directory, call Member Services toll-free at **1-888-980-8728** (TTY **711**). You can ask about provider information such as:

- Medical school attended
- Residency

If you have original Medicare and QUEST Integration, you don't have to use the doctors on this list. You can go to any doctor that takes Medicare. If you have a Medicare Advantage plan, check with that plan on your choice of doctors and other providers.

Seeing another doctor or specialist

Your PCP might want you to go to a specialist. A specialist is a provider that treats a special health problem, like an allergy doctor or a heart doctor. Your PCP will refer you to specialists when needed. Your PCP may give you a referral form if you need one. (Give the form to the specialist when you go to see them.) If you have a complex illness, you may need to see the specialist several times or need to see several specialists.

What is a referral?

A referral is from your PCP for you to see a specialist or get services.

A referral is not needed when you see any in-network specialist that your PCP refers you to. A referral is not needed if you need emergency services. It is not needed to see a women's health care provider for women's health care services. This is called "direct access" or the ability to refer yourself for women's health services. This includes new members that are pregnant and in their second or third trimester the day before they are enrolled with UnitedHealthcare Community Plan that are already receiving prenatal services from an out-of-network OB/GYN. You may continue to receive care from your out-of-network OB/GYN through delivery and postpartum (after delivery) services without a referral or prior authorization.

UnitedHealthcare Community Plan financial arrangements with providers do not affect referrals or other services. To learn more, call Member Services toll-free at **1-888-980-8728** (TTY users **711**).

Out-of-network and out-of-state providers

You or your PCP might decide that you need to see a provider for services or treatment not available in our provider network or not available within the State of Hawai‘i. Your PCP will need to call us to get an approval or authorization before these services will be covered. This is called a prior authorization. You will not be charged any additional costs when seeing an out-of-network provider with a prior authorization.

If you have other health insurance coverage such as Medicare or employer group coverage

Your QUEST Integration plan is the last payer to your other health insurance coverage. If you go out of network to another island, or out-of-state, we may not pay for unauthorized services, even if covered by your other coverage. This would include coverage of copays, coinsurance, deductibles and other services such as transportation. We will cover as the last payer for emergent/urgent services out of network and out-of-state. Please check with us before going out of network, travel to another island, or travel out-of-state for non-emergent services when you have other insurance coverage.

You will need prior authorization if you want to see a provider that is not in our QUEST Integration plan network including out-of-state providers (providers that are not in Hawai‘i). You do not need prior authorization for emergencies, urgent care or for direct access to women health services.

What if I need a second opinion?

You can get a second opinion for your health care at no cost. Call your PCP if you want a second opinion from an in-network provider unless an in-network provider is not available. A prior authorization is required to see an out-of-network provider. If the out-of-network provider asks for tests, those tests must be performed by an in-network provider. You can also call Member Services toll-free at **1-888-980-8728** (TTY users **711**) if you need help in finding a doctor for a second opinion.

Member’s right to refuse treatment

You have the right to refuse any medical service, diagnosis, or treatment or to refuse to accept any health service provided by UnitedHealthcare Community Plan. This includes objecting on religious grounds.

Religious or moral objections

UnitedHealthcare Community Plan has no moral or religious objections that could prevent or limit the care you receive under the QUEST Integration program. We will cover the health benefits described in this Member Handbook.

While UnitedHealthcare does not have any institutional moral or religious objections that could prevent or limit the care that you receive under the QUEST Integration program, UnitedHealthcare has a process in place to ensure our members receive the necessary services. This process includes appropriate notification to our members, potential members, and the DHS that will include information on how to obtain services that we may no longer provide as a result of a potential moral or religious objections. Notification will be provided either through a post card by mail, member newsletter (Health Talk), secured and public portals or website. If you need detailed information about our process, you may contact Members Services toll-free at **1-888-980-8728** (TTY users **711**) for assistance.

Should your provider have a religious or moral objection about a course of treatment you would like to receive, we will assist you in finding another provider that can provide the treatment or services you may need. **You may contact Members Services toll-free at 1-888-980-8728 (TTY users 711) for assistance.**

What is cost share (enrollment fee)?

Members that have been approved by the DHS to receive Long-Term Services and Supports (LTSS) benefits may have to share in the cost of their health care services as determined by the Department of Human Services (DHS). This is called or referred to as cost share, share of cost or enrollment fee. This is determined based on Medicaid financial eligibility requirements and your DHS case worker will figure out the amount of your cost share and will let you know in writing what your monthly cost share amount will be. The DHS will also tell us what your monthly share of cost amount is through a daily file. If you have a cost share, you must pay that amount to one of your providers (e.g., community care foster family home or nursing facility) or UnitedHealthcare every month. We will review our records monthly to determine if you have met the cost share requirement determined by the DHS. If the amount of your cost share has not been met or paid, we will let you know in writing and we may also contact you by telephone to discuss any unpaid amount.

There are two ways that we will notify you in writing:

Cost share monthly statement — We will send you a monthly statement to provide you with a history of your monthly cost share information that will list information from the first month of when the DHS determined your cost share responsibility regardless of the balance or remaining amount for each period. The monthly statement is not a bill and this is just for your records.

Cost share invoice — We will send you a monthly invoice for any unpaid or outstanding cost share amounts that you are responsible for. The monthly cost share invoice is a bill and you must pay in full any outstanding cost share amounts upon receiving your invoice.

How do I pay my outstanding cost share balance?

You can call Members Services toll-free at **1-888-980-8728** (TTY users **711**) to make your payment with a representative over the telephone. You can pay with your checking/savings account or with a credit or debit card.

You also have the option to pay by mail. If you choose to pay by mail, you can send a personal check, cashier's check, or money order to the mailing address that is listed on your invoice. You must include the payment stub from your invoice with your payment to ensure timely and accurate posting and allocation of your payment into our system.

Will my cost share responsibility amount change?

Your DHS case worker will let you know in writing when there is a change in your cost share responsibility. Your cost share amount may change based on information that you report to the DHS or based on information that the DHS may receive from Social Security and other financial entities or institutions. Your cost share amount may increase or decrease. Your DHS case worker will also let us know when there is a change in your cost share responsibility. We will let you know by mail if you need to pay UnitedHealthcare any additional or outstanding cost share amount. Our system is updated based on information that is received from the DHS. Contact your DHS case worker if you feel that the cost share amount in our system is different than the cost share information you received from the DHS.

What if my cost share amount is not correct?

Call Member Services toll-free at 1**-888-980-8728** (TTY users **711**) for assistance. They will help you research and resolve the issue. They may tell you to call your DHS case worker to help resolve the issue. Our system will be updated based on any changes received from the DHS.

What happens if I leave the nursing facility in the middle of the month and go home, do I get my cost share back?

Your cost share amount is calculated by the State from the first day of the month and has already been applied towards your care. Cost share amounts are not prorated for the number of days you are in the facility. For the month after you go home, your eligibility will be redetermined based on your new living arrangements and your needs.

What happens if I die in the beginning of the month, will my family, payee or authorized representative be refunded for payments made to the community care foster family home or nursing facility?

Your cost share amount is calculated by the State from the first day of the month and has already been applied towards your care or services for that month. Cost share amounts are not prorated if member passed away during the month nor prorated for the number of days you are in the facility.

Unpaid cost share amounts

Any unpaid cost share amounts that remain outstanding for at least two months in a row will be reported to the DHS for those members that live in their own home. The DHS may terminate your Medicaid eligibility due to non-payment. If your Medicaid eligibility is terminated you will have to reapply for Medicaid benefits again. You will still be responsible for any unpaid or outstanding cost share amounts even if your Medicaid eligibility has been terminated.

Premium and cost-sharing collection for Indian members

To ensure that you have access to Indian Health Services as per Title 42, United States Code, Section 13960(a), and Title V of the American Recovery and Reinstatement Act of 2009, Section 5006, any Indian members that are eligible to receive or have received an item or service provided by an Indian Health Care Provider or through a referral under contract health services, are exempt from having any cost-sharing or premium amounts or fees. Cost-sharing amounts related to services provided by an Indian Health Care Provider or through a referral under contract health services, refers to any copayment, coinsurance, deductible or similar charge.

If you receive a bill for services provided through an Indian Health Care provider or through referral under contract health services for any copayment, coinsurance, deductible or similar charge, please contact Member Services toll-free at **1-888-980-8728** (TTY users **711**) so that we can work with the provider to resolve the billing issue to make sure that you are not held responsible or liable for those fees or charges.

Scheduling a doctor's appointment

Call your PCP to schedule an appointment. The phone number is on the front of your member ID card. Give the office:

- Your PCP's name that is listed on your member ID card
- Your QUEST Integration member ID number (on the front of your member ID card)
- Any other health insurance coverage information, such as Medicare
- The name of the person who needs to see the doctor (and their information if other than yourself)
- Why you need to see the doctor

Once you have made the appointment:

- Be on time for your appointment
- If you cannot keep your appointment, call the doctor's office immediately to reschedule your appointment
- The doctor cannot charge you a "no-show" fee if you do not show up for your appointment

Things to discuss with your doctor during your appointment:

- Ask your PCP if you need or are due for any tests or screenings (i.e., mammograms, pap smear, cervical cancer, osteoporosis, cholesterol, colorectal screenings, diabetes, etc.)
- Share with your doctor a list of any health changes since your last visit
- Share with your doctor any health goals, such as losing weight, getting pregnant or quitting smoking

Getting needed care

- Concerns with getting the care, tests or treatments you need
- Scheduling routine care appointments in advance
- Where and how to get urgent care when you need it right away
- Coordinating the care that you need or get from other doctors or specialists
- Difficulties getting appointments with a specialist, if needed

Prescription drugs

- Any questions with the prescription medications you are taking
- Issues getting the medicines your provider prescribes

Important care

- Suggestions on how to improve your physical activity
- Ways to help if you are feeling sad or blue

Tests and treatments

- When you will get results from labs, X-rays or other tests

Things to discuss with your child's doctor during your child's appointment:

- Ask your child's PCP if your child is due for any tests, screenings or immunizations
- Share with your child's doctor a list of any health changes since your child's last visit
- Share with your child's doctor any health goals you may have for your child

Getting needed care

- Concerns with getting the care, tests or treatments your child needs
- Scheduling routine care appointments in advance
- Where and how to get urgent care when your child needs it right away
- Coordinating the care your child needs or gets from other doctors or specialists
- Difficulties getting your child appointments with a specialist, if needed

Prescription drugs

- Any questions with the prescription medications your child is taking
- Issues getting the medicines your child's provider prescribes

Important care

- Suggestions on how to improve your child's physical activity
- Ways to help if your child is feeling sad or blue

Tests and treatments

- When you will get your child's results from labs, X-rays or other tests

If you need help making an appointment, you may call Member Services toll-free at **1-888-980-8728** (TTY users **711**) for assistance.

How long should it take to get a PCP or doctor's appointment?

Timely access to services

Here are guidelines on how long it takes to get an appointment. You may also call Member Services toll-free at **1-888-980-8728** (TTY users **711**) with any questions or for assistance in scheduling an appointment.

Acceptable appointment wait times Appointment wait time is based on the date of when the appointment is requested		
Medical appointments		
Type of visit	**Examples of care needed**	**Appointment wait times**
Emergency Care	When you have trouble breathing, head injury, broken bones, overdose or poison.	Immediately — Go to the nearest emergency room right away. Prior approval is not needed. Available 24 hours, 7 days a week.
Urgent Care	Medical care that is not an emergency but needs to be taken care of within 24 hours to treat serious symptoms.	Within 24 hours
PCP Child Sick Visits	For symptoms such as a runny nose, coughing, or sneezing.	Within 24 hours
PCP Adult Sick Visits	For symptoms such as a runny nose, coughing, or sneezing.	Within 72 hours
Routine PCP Visits for Children/ Adults	Care such as well-child visits, routine follow-up care or check-ups.	Within 21 days
Routine Specialist Visits for Children/ Adults	Wellness checkups, physical exams, X-rays, heart problems, lungs, or foot.	Within 4 weeks

Acceptable appointment wait times Appointment wait time is based on the date of when the appointment is requested		
Type of visit	**Examples of care needed**	**Appointment wait times**
Inpatient Hospital Stay (Non-Emergent)	Care such as surgery or a procedure that can be done only in a hospital.	Within 4 weeks
PCP Referrals to see a Specialist	For heart condition, lungs, neurological, liver, etc.	As soon as possible or in time to meet medical necessity but no more than 4 weeks of the referral.
PCP Referrals to see a Specialist for Urgent Care	Medically necessary care that is needed to treat a serious medical injury or illness.	Within 24 hours of the referral

Behavioral health appointments		
Type of visit	**Examples of care needed**	**Appointment wait times**
Emergency	When you have symptoms such as having thoughts of hurting yourself or others, not feeling safe in your home or in the community.	Immediately — Go to the nearest emergency room right away. Prior approval is not needed.
Urgent	When there are sudden problems that are not emergencies. For example, when you have increased anxiety, depression or stress. When you have urgent medication needs such as refills or medication changes.	Within 24 hours
Routine Care	Regular visits with your therapist or doctor or when you have medication changes or renewals.	Within 21 days

If you need help making an appointment, call Member Services toll-free at **1-888-980-8728** (TTY users **711**).

If you feel you need to see the doctor right away, tell this to the person who answers the phone at the doctor's office.

What if I need medical care and my doctor's office is closed?

Call your PCP if you need care that is not an emergency. If you call your doctor after normal business hours, your call may be directed to an after-hours answering service staff that will help connect you with your doctor. Your doctor will provide you with instructions to ensure that you get immediate care.

For example, you may be directed by your doctor to:

- Call NurseLine toll-free at **1-888-980-8728** (TTY users **711**)
- Connect with UHC Doctor Chat at **UHCDoctorChat.com**, or download the UHC Doctor Chat app to connect to a doctor (this is a telehealth visit)
- Go to an after-hours clinic or urgent care center
- Go to the office in the morning
- Go to the Emergency Room (ER)
- Get medication from your pharmacy

What if I need medical care when I am off-island or out of the state?

Non-emergent or non-urgent care (routine care)

You can receive 24 hours non-emergent or non-urgent medical care from anywhere from the following providers:

NurseLine — Refer to **page 48** on how to reach or chat with a nurse.

UHC Doctor Chat — Refer to **page 49** on how to connect with a doctor online.

If you need to get to the ER, call 911.

We will pay for routine care out-of-state only if:

- You call your PCP first and he or she says that you should get care before you return home
- Your PCP must then call us to get approval in advance. If you do not speak to your PCP before you get routine care away from home, you may have to pay for care yourself. If you cannot reach your PCP, call Member Services.
- Any provider you see in person must agree to accept Hawai‘i Medicaid payment

This means if you or your family are on vacation and need routine care, we will pay only if you get our approval first.

Emergency care

If you need emergency care at any time, including when you are on another island or out of the state, go immediately to the nearest Emergency Room (ER). You do not need a prior authorization to go to the ER. You can also go to an urgent care center. You do not need a prior authorization to go to an urgent care center. Call your PCP as soon as you can after getting ER or urgent care services so that your PCP can help coordinate additional services that you may need while you are out of the State or schedule an appointment for a follow-up visit with your PCP when you return home.

Note: We will only pay for urgent or emergency services and care after an emergency hospital stay until you are safe to come back to Hawai‘i. We will also pay out-of-state services that we have approved in advance.

If you decide to move to another State while you’re on vacation or away from Hawai‘i, you must notify your DHS case worker immediately of the change or your intent to move out-of-state.

We will only pay for urgent or emergency services and care after an emergency hospital stay until you are safe to come back to Hawai‘i. We will also pay out-of-state services that we have approved in advance. Approval is required even if you have other insurance coverage, such as Medicare, in order for us to cover any copays, coinsurance and deductibles for non-emergency transportation services off-island or out-of-state.

No coverage outside of the United States

Any services you receive while outside of the United States will not be covered by UnitedHealthcare Community Plan. Medicaid does not cover any services you get outside of the United States.

NurseLine

As a member of UnitedHealthcare Community Plan, you can use our NurseLine 24 hours a day to talk to a registered nurse. You can also visit **myuhc.com/CommunityPlan** for Nurse Chat. Nurse Chat is our online instant message version of NurseLine.

NurseLine is staffed with nurses who have an average of 15 years of experience. NurseLine uses trusted, doctor-approved information to help you make health care decisions for you and your family. All at no cost to you.

Getting the best care begins with asking questions and understanding the answers. NurseLine can help you make health decisions for you and your family. A NurseLine nurse can even give you tips on eating healthy and staying fit or connect you with a doctor. The nurse can also help you with:

- Minor injuries
- Common illnesses
- Self-care tips and treatment options
- Recent diagnoses and chronic conditions
- Choosing appropriate medical care
- Illness prevention
- Nutrition and fitness
- Questions to ask your doctor
- How to take medication safely
- Men's, women's and children's health

Call NurseLine services toll-free at 1-888-980-8728 (TTY users **711**).

UHC Doctor Chat

UHC Doctor Chat is a telehealth provider that is available to you anytime and anywhere. You can use UHC Doctor Chat for urgent care and non-emergency primary care visits. Now seeing a doctor is easier than ever, with online video visits. UHC Doctor Chat can make it easy for you to see an online doctor for minor illnesses when your PCP is not available right away. UHC Doctor Chat doctors can treat illnesses like cold and flu, pink eye, nausea and more.

You will be seen by doctors who are licensed by the State of Hawai‘i. If medically necessary, your doctor will send prescriptions and refills to your pharmacy. They’re ready when you are.

Doctors are available online anytime, day or night. Even on weekends and holidays. It’s private, secure and easy. Now you can visit the doctor’s office without going to their office. As a member of UnitedHealthcare Community Plan, there is no cost to you.

Get started

Visit **UHCDoctorChat.com**, or download the UHC Doctor Chat app to register or for assistance. Register with your UnitedHealthcare QUEST Integration member ID number. Open the UHC Doctor Chat and connect with a doctor.

Common conditions we treat:

- Allergies, rashes
- Coughs, fevers, sore throat, ear-aches
- Diarrhea/constipation
- Headache, back and abdominal pain
- Animal/insect bites
- Nausea, vomiting, stomach pain
- Pink eye
- Urinary problems/UTI
- Sports injuries, burns, heat-related illness
- And many more

Benefits and services

Covered benefits

These QUEST Integration services are provided by UnitedHealthcare Community Plan. Some of these benefits need prior authorization. This means that your PCP or provider must contact us before starting the service. Your PCP will coordinate the referrals to other doctors or specialists. Hospitals and facilities will notify us of any admissions or services that need notification. You must have authorization from us for any out-of-network services. You do not need an authorization for out-of-network emergency, urgent care, emergent family planning or emergent women's health services.

All members will receive covered medically necessary services regardless of their health status or need for health care services, religion, race, color, creed, national origin, ancestry, sex, gender identity or expression, income status, or disability.

Your doctor can request the referral by calling us toll-free at **1-888-980-8728** (TTY users **711**). If you have questions about your benefits, please talk to your PCP or call Member Services toll-free at **1-888-980-8728** (TTY users **711**). You can also sign in to **myuhc.com/CommunityPlan** and search your benefits under the section "Benefits" or use the UnitedHealthcare app to learn more about your benefits.

Covered benefits	Description	Limitations
Acute Waitlisted Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF)	ICF or SNF level of care services provided in an acute care hospital in an acute care hospital bed.	Prior authorization needed. Notification and Concurrent Review required. Facility must notify the Plan.
Alcohol and Chemical Dependency Services	Substance abuse services in a treatment setting accredited per State of Hawai'i Department of Health Alcohol and Drug Abuse Division (ADAD) standards. Counselors must be certified by ADAD.	Prior authorization needed.

Covered benefits	Description	Limitations
Ambulatory Mental Health Services and Crisis Management	Includes twenty-four (24) hour access line, mobile crisis response, crisis stabilization, crisis management and crisis residential services.	
Behavioral Health Drugs and Medication Management	Evaluation, prescription, maintenance of psychotropic drugs, medication management, counseling, education, promotion of algorithms (determining illnesses vs. a concern, urgent or non-urgent psychological assessments) and guidelines.	
Behavioral Health – Outpatient	Includes visits to psychologists, psychiatrists or behavioral health APRNS.	
Cancer-Related Treatment	Access to any related medically necessary service. This includes, but is not limited to, hospitalization, doctor services, other practitioner services, outpatient hospital services, chemotherapy and radiation, or hospice.	

Covered benefits	Description	Limitations
Clinical Trials	A clinical research study that is also called a "clinical trial" is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe. There are two main types of clinical studies: Clinical trials, also called interventional studies and observational studies. **(continues on next page)**	**Limitations:** Only approved clinical trials offered by the National Institutes of Health (NIH), including National Cancer Institute (NCI), Centers of Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD), Department of Energy (DOE), Department of Veterans Affairs (VA), including trials conducted under an investigational new drug application (IND) reviewed by the Food and Drug Administration (FDA), are covered. **(continues on next page)**

Covered benefits	Description	Limitations
Clinical Trials (continued)	**Covered services:** Routine patient care costs. Includes all items and services that are normally covered under the QUEST Integration plan that would be covered if you were not involved in a clinical trial. Items or services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications. Items or services needed for medically necessary care arising from the provision of an investigational item or service, in particular, for the diagnosis or treatment of complications.	**Services excluded:** Includes but are not limited to the following: • Investigational item or service unless otherwise covered outside of the clinical trial • Items/services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management of the patient • Items/services customarily provided by the research sponsors fee-of-charge for participation in the trial • Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the QUEST Integration plan • Items/services excluded from QUEST Integration plan coverage; and items/services for a clinical trial that does not have therapeutic intent (trials that are designed exclusively to test toxicity or pathophysiology without therapeutic intent) **(continues on next page)**

Covered benefits	Description	Limitations
Clinical Trials (continued)		**Exception:** We will cover travel and transportation expenses if not covered by the approved agency that is sponsoring or conducting the clinical research study. **In-network providers (must be located in Hawai‘i):** Covered. **Out-of-network providers:** Not covered.
Cognitive Rehabilitation Services	Services to help you with daily living activities due to a traumatic brain injury. These services will help assess and determine treatment for problems you may experience with your ability to: • Communicate • Remember things • Self-awareness • Pay attention Services includes assessments and reassessments that are done regularly as to ensure treatment goals are met.	

Covered benefits	Description	Limitations
Dental Services to Treat a Medical Condition	**UnitedHealthcare will only cover dental services to treat medical conditions even if you have other insurance coverage that is primary to Medicaid. Services include:** • Medical services related to dental needs • Dental or medical services provided in a hospital or surgery center because of a dental or medical condition • Emergency services by a dentist or oral surgeon, plastic surgeon, otolaryngologists and general surgeons due to a traumatic injury; for example, a car accident • Referrals, follow-ups, coordination for dental services to treat medical conditions • Coordination with the DHS or its agents for appropriate referrals, care coordination to ensure timely appointments, transportation and translation services **(continues on next page)**	

Covered benefits	Description	Limitations
Dental Services to Treat a Medical Condition (continued)	**Note:** For members with other coverage that is primary to Medicaid with dental benefits (i.e., Medicare Advantage or Commercial plan, etc.), please check with your primary insurance plan on dental benefits to ensure appropriate benefit coordination with the DHS dental coverage. UnitedHealthcare will only cover dental services to treat medical conditions even if you have other insurance coverage that is primary to Medicaid.	
Diabetes Self-Management Education (DSME)	Diabetes self-management education services related to diabetes or gestational diabetes. **Diabetic supplies:** Diabetic supplies include but not limited to, alcohol swabs, syringes, test strips and lancets. Diabetic supplies can be from a participating pharmacy. Or they can be delivered to your home (from our mail order pharmacy, OptumRx®).	

Covered benefits	Description	Limitations
Dialysis	Includes dialysis services through approved facilities. Services include but are not limited to the following: • Laboratory test • Hepatitis B vaccines • Alfa Epoetin • Other drugs related to End State Renal Disease • Home dialysis equipment and supplies prescribed by a physician • Continuous ambulatory peritoneal dialysis • Physician's services, and • Inpatient hospitalization	

Covered benefits	Description	Limitations
Durable Medical Equipment and Supplies	**Equipment and supplies for medical purpose** May include, but are not limited to: oxygen tanks and concentrators; ventilators; wheelchairs; crutches and canes; orthotic devices; prosthetic devices; pacemakers; breast pumps; incontinence; and medical supplies. **Incontinence supplies (diapers, underpads, liners)** Call Medline Industries if you need to place an order for diapers, underpads, liners and other incontinence products or if you have questions about your order. You may have questions about the address that your order was mailed to, need to update the address for your order, or you want to check on the status of your order. Call Medline Industries toll-free at 1-877-816-5587 between the hours of 7:45 am.–4:30 p.m. HST, Monday–Friday. **(continues on next page)**	Prior authorization needed for any item over $500. Prior authorization is needed for enteral services and incontinence supplies.

Covered benefits	Description	Limitations
Durable Medical Equipment and Supplies (continued)	**Breast pumps** Your doctor can fax a prescription or an order to TENS Unlimited to fax number 808-200-0391. You may also call TENS Unlimited at 808-772-0226 to request a breast pump and they will work with your doctor to obtain a prescription or a completed order form. Or you can call Member Services toll-free at **1-888-980-8728** (TTY users **711**). They can help connect you with Medline Industries or assist you with your questions related to incontinence supplies and/or to TENS Unlimited for assistance with any questions related to breast pumps.	

Covered benefits	Description	Limitations
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services	Services include: • Regular preventive comprehensive well-child exams • Screenings including (but not limited to): – Alcohol and drug use assessment – Depression – HIV – Sexually transmitted infection (STI) • Growth and Development chart to include (when appropriate): – Height – Weight – Body mass index – Blood pressure measurements • Immunizations (shots to prevent diseases) • Eye exams/eye wear • Hearing exams/aids • Prescription medications • Nutritional health and education • Lead risk assessment and testing as appropriate • Lab tests as needed • Regular preventive dental and treatment services including: – Screening examinations – Prophylactic treatments (scaling and polishing) **(continues on next page)**	For children under the age of 21 years. **Note:** Members ages three (3) to under twenty-one (21) can receive EPSDT well-child exams.

Covered benefits	Description	Limitations
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services (continued)	• Any medically necessary treatments for abnormal findings during well-child exams including referrals to: – Specialists – Dentists – Counselors – Behavioral and mental health assessment – Behavioral therapies to include: ◦ Applied Behavioral Analysis (ABA) for members with an autism spectrum disorder (ASD) diagnosis ◦ Counseling treatments for drug and alcohol use for adolescent • Any needed services as part of a treatment plan that is approved as medically necessary to correct or improve defects of physical, mental/emotional or dental illness and conditions discovered as a result of EPSDT screens • Help with making appointments, getting to and from appointments (upon request), and care coordination services, as needed For more information, please see **Additional behavioral health services** on **page 83**. **(continues on next page)**	

Covered benefits	Description	Limitations
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services (continued)	**Interperiodic screens** EPSDT screens that occur between the comprehensive EPSDT periodic screens to help determine the existence of physical or mental health conditions. An example is a physical exam that is required by the child's school in order for the child to participate in school sports when a comprehensive periodic screen was performed on the child more than three (3) months earlier.	
Emergency, Post-Stabilization and Urgent Care **Covered Anywhere in the USA.**	For a medical emergency or urgent care. Post-stabilization is care after an emergency to keep you stable. You can get these services 24 hours a day, 7 days a week at any emergency room. You can also go to urgent care centers.	
Family Planning	Help to make informed choices and prevent unplanned pregnancy. You can go to any provider that offers these services. Also includes family planning drugs, supplies and devices. These include, but are not limited to, generic birth control pills, birth control shots, IUDs and diaphragms, sterilization procedures, education and counseling.	

Covered benefits	Description	Limitations
Habilitation Services	Habilitative services and devices to develop, improve, or maintain skills and functioning for daily living that were never learned or acquired to an appropriate level. • Audiology services • Vision services • Related devices including communication devices, reading devices, and visual aids • Occupational therapy • Physical therapy • Speech-language therapy	Prior authorization needed except for physical, occupational, or speech therapy. Does not include routine vision services. Exclusion: Devices used solely as school-based or devices that are provided by the school for use in the school and/or at home for home-bound children when medical necessity has not been met.

Covered benefits	Description	Limitations
Hearing Services	Includes diagnostic screening, preventive visits, and hearing aids. Hearing aid coverage is for both analog and digital and includes coverage for service, loss (replacement), damage warranty, trial or rental period.	**Initial evaluation/selection:** 1 per year. **Electro-acoustic evaluation:** Four (4) per year for members under four (4) years old; Two (2) per year for members four (4) years and older. **Fitting/orientation/hearing aid check:** Two (2) per year for members under the age of twenty-one (21) and 1 per year for members over twenty-one (21) years old. **Hearing aid device:** 1 per ear, per every twenty-four (24) months. **Prior authorization** is required for hearing aid devices and replacements during the warranty period or within three (3) years of the purchase or replacement of another hearing aid. If your primary insurance coverage (i.e., Medicare or a Commercial plan) does not cover hearing aid devices, your provider must request a prior authorization from us to cover the hearing aid device under your QUEST Integration benefit. Hearing aid devices can be obtained from any of our participating providers. Call Member Services if you need help in finding a hearing aid provider toll-free at **1-888-980-8728** (TTY users **711**).

Covered benefits	Description	Limitations
Home Health	Includes medical equipment and supplies, therapy or rehabilitative services such as physical and occupational therapy, audiology and speech-language, skilled nursing care and home health aides.	Prior authorization needed.
Hospice	Care if you are terminally ill and are expected to live less than six (6) months. Children under the age of twenty-one (21) years may receive treatment to manage or cure their disease while also receiving hospice services. Hospice services may be provided in a hospital, stand-alone nursing facility, Community Care Foster Family Home (CCFFH) or in your own home.	Prior authorization is needed for hospice services provided in an inpatient hospital setting. Prior authorization is not needed for hospice services provided in a stand-alone Skilled Nursing Facilities, CCFFH or in your own home. Services must be received from an agency certified by Medicare. UnitedHealthcare will not cover hospice services that are provided to members receiving Medicare hospice services that is duplicative of Medicare hospice benefits. Examples include personal care and homemaker service. This is only covered when the service need is not related to the hospice diagnosis.

Covered benefits	Description	Limitations
Hospital – Behavioral Health Inpatient (BH)	Services includes inpatient psychiatric hospitalization (room/board, nursing care, medical supplies, equipment, diagnostic services, psychiatric and other behavioral health practitioner services, ancillary services, other medically necessary services.	Hospital must notify the Plan.
Hospital – Inpatient	Inpatient hospital care includes medical, surgical care to include post-stabilization services, maternity and newborn care, sterilization and hysterectomies, nursing care, medical equipment, supplies, drugs, diagnostic services, physical and occupational therapy, audiology, speech-language as well as any emergency inpatient care.	Hospital must notify the Plan.

Covered benefits	Description	Limitations
Hysterectomies	**Hysterectomy services are covered when the following conditions are met:** • Member has given informed consent • The member has been informed verbally and in writing that a hysterectomy will render the Member permanently incapable of reproducing. This is not needed if member is already sterilized or in the case of an emergency hysterectomy. • The member has signed and dated the consent form in advance of the hysterectomy (HHS 687) • Interpreter services is provided when language barrier exist. Arrangements are to be effectively to communicate the required information to a member who is visually impaired, hearing impaired or otherwise disabled. • Member is not institutionalized in a correctional facility, mental hospital, or other rehabilitative facility • A court order is required for members that are incapacitated	**Not covered if:** • Performed solely for the purpose of rendering the Member permanently incapable of reproducing • There is more than one (1) purpose for performing the hysterectomy but the primary purpose is to render the Member permanently incapable of reproducing • It is performed for the purpose of cancer prophylaxis when not medically indicated

Covered benefits	Description	Limitations
Immunizations	Includes but not limited to influenza, pneumococcal, diphtheria, COVID-19, and tetanus. **Refer to page 78 for information on vaccines for children (VFC) under the age of 18 years old.**	
LTSS Services: Skilled Nursing Facility (SNF)/Intermediate Care Facility	Care by licensed nursing professionals in a nursing facility to members who need 24-hour-a-day help with daily living on a regular, long-term basis.	Prior authorization needed. Facility must notify the Plan.
LTSS Services: Sub-Acute Facility	Care by licensed nursing professionals in a facility with a more intensive level of care than a skilled nursing facility.	Prior authorization needed. Facility must notify the Plan.
Methadone Management	Methadone/levo-alpha-acetyl-methadol (LAAM) services for adult members for acute opiate detoxification and maintenance.	Prior authorization needed.
Newborn Care	Newborn hearing assessment, laboratory screening, delivery, inpatient hospital related services, outpatient services, EPSDT services, circumcision and other needed newborn care services.	Newborn is an individual that is 28 days old or less.
Nutrition Counseling	Preventive health service includes nutrition counseling for diabetes, obesity, and other metabolic conditions.	Prior authorization is needed. Limitation: Requires a physician's order and shall be part of a treatment program to mitigate the effects of a medical condition.

Covered benefits	Description	Limitations
Outpatient – Hospital or Surgery Center	Services include but are not limited to: • Emergency services • Urgent care services • Medical supplies, equipment and drugs • Diagnostic services and therapeutic services including chemotherapy and radiation therapy • Sleep studies, and • Surgeries in an ambulatory surgery center (free-standing ASC and hospital ASC)	Prior authorization needed for some surgeries. You or your PCP can call the Plan.
Outpatient – Practitioner and Physician Visits	Services at a hospital or care center when you stay less than a day. Doctor, other provider visits, family planning, nutrition counseling, preventive services, and clinic visits.	
Podiatry Services	Services include, but are not limited to, the treatment of conditions of the foot. Services include foot and ankle care related to the treatment of infection or injury in an office or outpatient clinic setting; bunionectomies when bunion is present with overlying skin ulceration or neuroma secondary to the bunion.	

Covered benefits	Description	Limitations
Pregnancy-Related Services	Maternity care is medical care you get for you and your baby. This will help your baby have the best chance to be strong and healthy. We cover all your pregnancy related medical care through your pregnancy. This includes care before, during and after the birth of your child so both you and your child stay healthy. Services include: • Prenatal and postnatal care (includes prenatal vitamins) • Radiology, laboratory and other diagnostic tests • Treatment of missed, threatened, and incomplete abortions • Delivery of the infant • Screening, diagnosis, and treatment for pregnancy-related conditions such as screening for maternal depression, and access to necessary behavioral and substance use treatment or supports • Lactation support for at least six (6) months • Breast pump • Educational classes on childbirth, breastfeeding, and infant care **(continues on next page)**	The plan does not limit a hospital stay to less than 48 hours following a normal delivery or 96 hours following a cesarean section. Elective cesarean is not covered.

Covered benefits	Description	Limitations
Pregnancy-Related Services (continued)	Services include (continued): • Counseling on healthy behaviors • Inpatient hospital services, physician and other practitioner services and any other related services that impact pregnancy outcomes • Perinatal care coordination for high-risk pregnancies	
Prescription Drugs	Drugs prescribed by your doctor. This includes education about how to take the drugs. This includes behavioral health prescription drugs for children receiving services from Child and Adolescent Mental Health Division (CAMHD). See our QUEST Integration drug formulary on **myuhc.com/CommunityPlan** for drugs that are covered.	Members with Medicare should use their Medicare Part D coverage first.

Covered benefits	Description	Limitations
Preventive Services	Services to keep you healthy and detect illnesses and diseases and include but are not limited to: • Immunizations • Screening for common chronic and infectious diseases • Clinical, non-clinical and behavioral interventions to manage chronic disease and reduce associated risks and complications • Support for self-management for individuals at high risk of developing healthy living • Counseling to support healthy living • Support for lifestyle change when needed • Screening for behavioral health and developmental conditions	

Covered benefits	Description	Limitations
Radiology/ Laboratory/Imaging/ Diagnostic Tests	Lab tests, imaging services, radiology services and diagnostic tests for the covered outpatient visits.	Prior authorization is required for: • Magnetic Resonance Imaging (MRI), • Magnetic Resonance Angiogram (MRA), • Position Emission Tomography, • Reference lab tests that cannot be done in the State, • Disease-specific new technology lab tests, • Psychological testing, • Neuropsychological Testing, • Cognitive testing, • Computerized tomography, or • Genetic tests.
Rehabilitation Services	Includes: physical, occupational, speech, language, breathing therapy and others.	

Covered benefits	Description	Limitations
Smoking Cessation	Programs to help you quit smoking and stay smoke-free. Services include FDA approved medications (including both nicotine and non-nicotine) and counseling. Counseling sessions include individual, group or phone counseling (problem-solving/skills training and social support). Counseling services shall be provided by the following licensed providers who have been trained on this service and are functioning within the scope of their practice: Physician, Dentist, Psychologist, Clinical Social Worker in behavioral health, Advance Practice Nurse Practitioners, Mental Health Counselor or Certified tobacco treatment specialists under the supervision of a licensed provider. Call Member Services toll free at **1-888-980-8728** (TTY users **711**) to help you find a stop smoking program.	Limitation: At least four (4) counseling sessions per quit attempt per benefit period. Each counseling session must be at least ten (10) minutes per quit attempt. Prior authorization: Prior authorization is not required for smoking cessation related services including FDA approved medication. Step Therapy is not required in order to enter into a smoking cessation program or to get smoking cessation treatment.

Covered benefits	Description	Limitations
Sterilization	Services to prevent you from having children. The Plan covers once requirements are met. Requirements include, but are not limited to: • The member is at least twenty-one (21) at the time of consent • The member is mentally competent • The member voluntarily gives informed consent on the Required Sterilization Consent Form (DHS 1145) • The provider completes the Required Consent Form (HHS 687) • At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery • In the case of emergency abdominal pain, at least (72) hours have passed since informed consent was given • In the case of premature birth, informed consent was given at least (30) days in advance of the expected delivery date • Member is not institutionalized in a correctional facility, mental hospital, or other rehabilitative facility • A court order is required for members that are incapacitated	Prior authorization needed.

Covered benefits	Description	Limitations
Transplants	We will cover cornea transplants and bone grafts. All other transplants are covered by the State of Hawai‘i Organ and Tissue Transplant Program (SHOTT). For more information on the types of transplants that are covered by the SHOTT Program please refer to **page 118**.	For members with Medicare or other insurance coverage that is primary to Medicaid, your Medicare or other insurance coverage will always pay first, and Medicaid will pay last: **Kidney Transplants for Adults (21 years old and older) with Medicare or other insurance carrier as their primary insurance:** • If you need or will have only a kidney transplant, we will cover your kidney transplant after we coordinate payment with your primary insurance carrier • If you need or have a kidney transplant plus another type of transplant (for example, a kidney transplant plus a pancreas transplant) your primary or other insurance payer will pay first for both transplants and then the SHOTT Program will pay last. The SHOTT Program will coordinate payment with your primary insurance carrier. **(continues on next page)**

Covered benefits	Description	Limitations
Transplants (continued)		**Kidney transplants for Children (under 21 years old) with Medicare or other insurance carrier as their primary insurance:** • We will refer the case to the SHOTT Program for review and they will let us know if they will cover the service. We will coordinate care with your doctor(s). • If the SHOTT Program accepts your case then they will coordinate payment with your primary insurance carrier • If the SHOTT Program does not accept your case then we will coordinate payment with your primary insurance carrier
Transportation (air and ground)	**Non-emergency transportation:** Transportation to and from covered appointments if you qualify and have no other way to get there. Lodging and meals if needed due to inter-island or out-of-state referral. **Emergency transportation:** Medically necessary ground and air ambulance.	Must meet definition of medical necessity. Refer to **page 146** for additional information on benefit limitation for individuals with Medicare or other Insurance Coverage that is primary to Medicaid. Prior authorization needed (only for non-emergency transportation). Trips to the pharmacy and for personal reasons are not covered.

Covered benefits	Description	Limitations
Vaccinations	Services include all necessary childhood immunizations.	Provided through the health plan. Vaccines for children under the age of 18 are available for free to qualified providers through the Department of Health's Vaccine for Children (VFC) program. Qualified providers are registered with the VFC program. UnitedHealthcare will cover or pay only for the vaccine administration fee for the vaccines that are available for free through the VFC program.

Covered benefits	Description	Limitations
Vision Services	Services include vision exams, prescription lens, eye glasses, cataract removal, prosthetic eyes and emergency care. Services also include miscellaneous vision supplies such as the lens, frames or other parts of the eye glasses as well as fittings and adjustments.	**Routine visits:** Limited to one (1) every twelve (12) months for members under age twenty-one (21) and every twenty-four (24) months for members twenty-one (21) years and older. Visits done more frequently may be allowed with prior authorization if medically necessary. **Visual aid:** Limited to one (1) pair of glasses or contact lenses (not both) every (24) months for both children and adults. For eye glasses, limit one pair of lens and one frame every 24 months. Contact lenses are covered if you have a condition that cannot be corrected with eye glasses. **(continues on next page)**

Covered benefits	Description	Limitations
Vision Services (continued)		**Prior authorization is required for the following:** • Contact lenses • New eye glasses with significant changes in prescription within the twenty-four (24) month period • Replacement for eye glasses or contact lenses that are lost, stolen or damaged within the twenty-four (24) month period • Polycarbonate glasses for adults twenty-one years and older • Bifocal lenses for members under the age of forty (40) years old **The following are excluded/ not covered:** • Orthoptic training • Prescription fee • Progress exams • Radial keratotomy • Visual training • Lasik procedure • Visual aids for cosmetic reasons
Limitations: The DHS may change the covered benefits. This may include increasing or decreasing services and/or limits. You will be notified in advance of any changes.		

Gender Dysphoria services and treatment

Gender Dysphoria is a condition in which there are different opinions between an individual's experienced, expressed, alternative gender and assigned gender (the state of not matching up, not fitting well with something else or difference between an individual's self-image and actual experience). This includes Gender Dysphoria in children, adolescents and adults.

Gender Dysphoria treatment and related services are provided without discrimination on the basis of race, color, national origin, sex, age, disability, sexual orientation, or gender identity (actual gender identity or perceived gender identity).

Treatment options

Treatment options include behavioral therapy, psychotherapy, cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy and includes certain surgical treatments.

Surgical treatment options

Surgical treatments for Gender Dysphoria may include the following: clitoroplasty, hysterectomy, labiaplasty, mastectomy, orchiectomy, penectomy, phalloplasty or metoidioplasty (alternative to phalloplasty), placement of testicular and/or penile prostheses, salpingo-oophorectomy, scrotoplasty, urethroplasty, vaginectomy, vaginoplasty and vulvectomy.

Other terms used to describe surgery for Gender Dysphoria include sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery and sex reassignment.

Benefit limitations and exclusions

Certain treatments and services are not covered. Examples include, but are not limited to:

- Treatment received outside of the United States
- Reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or Gender Dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics

- Cosmetic procedures

  Certain ancillary procedures, include but not limited to the following, are considered cosmetic and not medically necessary when performed as part of a surgical treatment for Gender Dysphoria:

  - Abdominoplasty
  - Blepharoplasty
  - Body contouring
  - Breast enlargement, including augmentation mammaplasty and breast implants
  - Brow lift
  - Calf implants
  - Cheek, chin and nose implants
  - Face/forehead lift and/or neck tightening
  - Facial bone remodeling for facial feminization
  - Hair transplantation
  - Injection of fillers or neurotoxins
  - Laser or electrolysis hair removal not related to genital reconstruction
  - Lip augmentation
  - Lip reduction
  - Liposuction (suction-assisted lipectomy)
  - Mastopexy
  - Pectoral implants for chest masculinization
  - Rhinoplasty
  - Skin resurfacing (i.e., dermabrasion, chemical peels, laser)
  - Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple)
  - Voice modification surgery (i.e., laryngoplasty, glottoplasty or shortening of the vocal cords)
  - Voice lessons and voice therapy

Talk to your doctor if you think you need these services.

Prior authorization

Prior authorization is required for all surgical procedures to determine medical necessity.

For assistance

For more information or if you have any questions, contact Member Services toll-free at **1-888-980-8728** (TTY users **711**) for assistance.

Additional behavioral health services – for members with autism spectrum disorder under 21

Children under 21 years of age who have an autism spectrum disorder diagnosis may receive Applied Behavior Analysis (ABA), or other covered services, if needed and suggested by their doctor. This includes screening, evaluation, making a treatment plan, and starting services.

If you think this would help but your child does not have an autism spectrum disorder diagnosis, your child's PCP can do the screening and get more help if your child needs it. We can also help. Your child might also be able to try ABA to see if it will help until a diagnosis is made.

If your child already has a diagnosis of autism spectrum, he or she may be able to start ABA services without having to get diagnosed again. We will work with your child's doctor to find the best services for them. All autism spectrum disorder services will need an approval before services start.

For more information, please see **What are EPSDT services** on **page 92**.

Covered LTSS benefits

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

UnitedHealthcare Community Plan offers LTSS in different settings:

- Services in your home or other residential setting such as a Community Care Foster Family Home (CCFFH)
- Services in an institution such as a nursing facility

All LTSS services require prior authorization.

You must qualify for Long-Term Services and Supports (LTSS) determined by the DHS

See the table below for UnitedHealthcare Community Plan's long-term services and supports benefits. LTSS benefits are in addition to covered QUEST Integration benefits such as hospital, physician and pharmacy coverage. LTSS benefits are usually provided if you are at a nursing facility level of care. All authorized LTSS services are documented in the member's Health Action Plan (HAP).

Some LTSS services may be available for members not at a nursing facility level of care, but are considered “at-risk.” “At-risk” is when a member could become nursing facility level of care without these services. Members who are determined by UnitedHealthcare Community Plan to be “at-risk” may receive one or more of the following services:

- Adult day care
- Adult day health
- Home delivered meals
- Personal assistance
- Personal Emergency Response System (PERS)
- Private Duty Nursing (PDN)

Voluntary withdrawal from LTSS

You may call your Health Coordinator toll-free at **1-888-980-8728** (TTY users **711**) if you do not wish to participate or receive LTSS services.

List of LTSS services

Below is a list of LTSS services. If you think you need any of these services or additional services, call Member Services toll-free at **1-888-980-8728** (TTY users **711**) or speak to your Health Coordinator (if you have one).

Service	Description and limitations
Adult Day Care	This is when you go to a center during the day that has activities for you to do and provided to four (4) or more disabled adult participants. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions for your health action plan (HAP). Therapeutic, social, educational, recreational, and other activities are also available.

Service	Description and limitations
Adult Day Health	This is when you go to a day program to get social and health services. This is for adults with physical or mental impairments that need extra care. Services may include emergency care, dietetic services, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech language pathology, and transportation services.
Assisted Living Services	These are personal care and supportive care services to help you with chores and meal preparation in an assisted living facility. UnitedHealthcare Community Plan does not pay for room and board in assisted living facilities. You must be receiving ongoing CCMA services.
Attendant Care	This is hands-on care for medically fragile children. Services includes member supervision, skilled or nursing care to the extent permitted by law. Housekeeping services that are incidental or related to the performance of care may also be provided. These services may be self-directed. The family must take part in the care of the home-based medically fragile child.
Community Care Foster Family Home (CCFFH) Services	These services include personal care, nursing, homemaker, chore, and companion services and medication oversight. They are given in a certified private home by a care provider who lives in the home. You will also receive case management services from one of our Community Case Management Agencies (CCMA).
Community Care Management Agency (CCMA) Services	These are care coordination services you may get if you live in Community Care Foster Family Homes (CCFFH), Expanded Adult Care Homes (E-ARCHs), Assisted Living Facilities (ALFs) and other community settings. Services include continuous and ongoing nurse oversight to the caregiver, initial and ongoing assessments to make recommendations to UnitedHealthcare Community Plan for services you may need.

Service	Description and limitations
Counseling and Training	These services are provided to you, your family, or your caregiver regarding the nature of the disease and disease process, methods of transmission and infection control measures, biological, psychological care and special treatment needs/regimens, employer training for consumer directed services, instruction about the treatment regimens, use of equipment specified in the health action plan, employer skills updates as necessary to safely maintain you at home, crisis intervention, supportive counseling, family therapy, suicide risk assessments and intervention, death and dying counseling, anticipatory grief counseling, substance abuse counseling, and/or nutritional assessment and counseling on coping skills to deal with the stress caused by member's deteriorating functional, medical or mental status. These services may be provided to you, family members, caregivers, and professional and paraprofessional caregivers on your behalf and may be done in your home or in another setting.
Environmental Accessibility Adaptations	These are changes to your home that are needed to keep you healthy and safe and keep you out of a nursing home or other facility. They must be required by your health action plan. They must be of medical benefit to you. They cannot be of general utility. They cannot add to the size of your home. Adaptations may include the installation of ramps and grab-bars, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for your welfare. Window air conditioners may be installed when it is medically necessary for your health and safety.
Home Delivered Meals	These are healthy meals delivered to your home. You cannot get more than two (2) meals per day. To get this service, you must not be able to make healthy meals yourself and you must need this to avoid moving to a nursing home or other facility. You may not live in a nursing home or residential facility to receive this service.

Service	Description and limitations
Home Maintenance	This is a service to keep your home safe and clean. These are not included as part of personal assistance. You may get this if you cannot do cleaning and minor repairs and need this service to avoid moving to a nursing home or other facility. Services include heavy duty cleaning (to bring your home up to acceptable standards of cleanliness), minor repairs to essential appliances and is limited to stoves, refrigerators, and water heaters, fumigation or extermination services.
Medical Transportation Services	For emergencies, transportation is provided even if you have another way to get to the hospital. For non-emergencies, UnitedHealthcare Community Plan will provide transportation to and from medical appointments if you qualify and have no other way to get there. UnitedHealthcare Community Plan will also provide transportation if you are referred to a provider on a different island.
Moving Assistance	This is provided in rare cases if your Health Coordinator finds that you need to move to a new home. Certain circumstances include unsafe home due to deterioration, you are wheelchair bound living in a building with no elevator, you live above the first floor of a multi-story building with no elevator, home is unable to support additional needs for equipment, eviction from your current home, or you are no longer able to afford the home due to increase in rental. Moving assistance includes packing and moving of belongings.
Non-Medical Transportation	This helps you get to certain services and activities when specified in your health action plan. When possible, you should use your family, neighbors, friends, or others who can provide this service for free. If you live in a residential care setting or a CCFFH, you cannot receive this service.

Service	Description and limitations
Nursing Facility Services	These services are when you need help from nursing staff 24 hours a day for a long period of time. Services include independent and group activities, meals and snacks, housekeeping and laundry services, nursing and social work services, nutritional monitoring and counseling, pharmaceutical services, and rehabilitative services.
Personal Assistance Services – Level I	These services provide help around the house so that you can live independently. The services may be self-directed. They may be limited to a maximum of 10 hours per week. There may also be a limit on the total number of members who may get these services for members who are not at a nursing level of care. Services may include light housekeeping tasks, meal preparation, laundry, shopping, and errands. Members that live or reside in a nursing facility setting such as a stand-alone Skilled Nursing Facility (SNF) or a Community Care Family Foster Home (CCFFH) are not eligible for these services.
Personal Assistance Services – Level II	These services are when you need help to perform activities of daily living and activities to keep you healthy. This service may be self-directed. Services may include personal hygiene and grooming, including bathing, skin care, help with mobility, transfers, medications, routine or maintenance health care services, help with feeding, nutrition, meal preparation and other dietary activities, help with exercise, positioning and range of motion, taking and recording vital signs including blood pressure, measuring and recording intake and output, when ordered, collecting and testing specimens as directed. Members that live or reside in a nursing facility setting such as a stand-alone Skilled Nursing Facility (SNF) or a Community Care Family Foster Home (CCFFH) are not eligible for these services.

Service	Description and limitations
Personal Emergency Response Systems (PERS)	This is a 24-hour service that helps you get help right away if you have an emergency. You can only get PERS if you live alone or are alone for long parts of the day and would otherwise need supervision. If you are in a nursing home or hospital, you cannot receive PERS. PERS include a variety of electronic devices and services that are designed for emergency assistance. Services include training, installation, repair, maintenance and response needs. PERS items include: • 24-hour answering or paging; • Beepers; • Med-alert bracelets; • Medication reminder services; • Intercoms; • Life lines; • Fire/safety devices, such as fire extinguishers and rope ladders; • Monitoring services; • Light fixture adaptations (e.g., blinking lights, etc.); • Telephone adaptive devices not available from the telephone company; and • Other electronic devices or services designed for emergency assistance.
Private Duty Nursing	This is when you need ongoing nursing care in your home or in the community and it is listed in your health action plan. These services can be self-directed under personal assistance level II/delegated using nurse delegation.
Residential Care Services	These services are help with personal care services, nursing, homemaker, chore, companion services, medication oversight (to the extent permitted by law) provided in a Type I or Type II Expanded Adult Residential Care Home by a care provider who lives in the home.

Service	Description and limitations
Respite Care	These services are when you can't care for yourself. These services are provided on a short-term basis when the person who normally provides care for you cannot do so or needs a break and can be provided hourly, daily and overnight. Services may be provided in your home or residence, Community Care Foster Family Home, Expanded Adult Residential Care Home, Medicaid certified Nursing Facility, licensed respite day care facility or other community care residential facility approved by the Plan. These services may be self-directed. Limitation: Respite care should not exceed any two-week period or be more than a total of thirty (30) days in a calendar year.
Specialized Medical Equipment and Supplies	These items help you perform activities of daily living or are needed for life-support. These items must be of direct medical benefit to you and your primary care provider must say you need them. This includes the purchase, rental, lease, warranty costs, assessment costs, installation, repairs and removal of devices, controls, or appliances specified in the health action plan. Items include specialized infant car seats, modification of parent-owned motor vehicle to accommodate the child (i.e., wheelchair lifts), intercoms for monitoring the child's room, shower seat, portable humidifiers, electric utility bills specific to electric life support devices and emergency back-up generators specific to electrical life support devices (ventilator, oxygen concentrator), medical supplies, heavy duty items such as patient lifts or beds, and miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceed $1,000 per month.

How do I get Long-Term Services and Supports (LTSS) including "at-risk" services?

To get long-term services and supports, you must meet the requirements determined by the DHS. You must have an assessment with your Health Coordinator to help determine what types of LTSS services you may need. Call your Health Coordinator or Member Services for more information.

All Covered Services are subject to change by the DHS. You will be notified in advance and in writing of any changes.

Can I direct my own care/services?

We want you to be involved in decisions about the services you get. If you are approved for personal assistance, respite care, or attendant care (for children), you have more options. For these services, speak to your Health Coordinator about directing your own care. This means you can choose, hire and/or change your provider. In some cases, you can pick a friend or loved one to do this for you. This individual is called a Self-Direct Provider. Call your Health Coordinator or Member Services to learn more.

Your Self-Direct Provider must meet certain minimum requirements, must be 18 years old, have a job history with relevant experience, a criminal background check, reference checks, IRS requirements and/or an interview. Self-Direct Providers can begin providing services after a start or employment date has been determined or agreed upon by both UnitedHealthcare Community Plan QUEST Integration and the Self-Direct Provider. We will not pay for any self-direct services that are provided before the Self-Direct Provider's start date or employment effective date.

Who can I call for help if I have additional questions?

Call Member Services toll-free at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m. HST, Monday–Friday. If you have one, you can also speak with your Health Coordinator or Care Manager.

How do I get primary and acute services?

You can call your Primary Care Provider (PCP) or Member Services. A list of UnitedHealthcare Community Plan QUEST Integration PCPs, specialists, hospitals, and other providers is in the provider directory. Please refer to the **Provider Directory** section on **page 36** for more information.

What are EPSDT services?

All members under the age of 21 on QUEST Integration are enrolled in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program and can get early screening for medical, dental and behavioral health conditions and be treated for conditions that are detected through EPSDT benefits. The EPSDT program provides for the delivery of medically needed services. Members under 21 years old on Medicaid living in foster homes or community residences are enrolled in the EPSDT program and can also get services.

Through the screening process, UnitedHealthcare and primary care providers will be able to identify members ages 0 to 3 who are developmentally delayed or biologically at-risk. UnitedHealthcare or PCPs will refer those members to the Early Intervention (EI) program. EI will evaluate and determine services that those members qualify for and will initiate the services. If you have concerns about your baby, call your primary care provider (PCP) or Early Intervention (EI) at 594-0066 (O‘ahu) or toll-free at 1-800-235-5477 (Neighbor Islands).

Members who are identified through the screening process with behavioral health challenges may be referred to the Support for Emotional and Behavioral Development (SEBD) program. This program is through the Department of Health, Child and Adolescent Mental Health Division (CAMHD).

All medically necessary EPSDT services are available to members under 21 years old. Services include:

- Well-child exams from newborn through age 20. Exams may include screenings for hearing, vision, developmental, autism, depression, or other behavioral health concerns. They may assess tuberculosis and lead risk. PCPs may include some blood screening, vaccines, and education. Referrals to specialists or further treatment may be medically necessary.

  Your child should have exams at the ages your child’s Primary Care Provider (PCP) recommends.

- Intensive Behavioral Therapies, e.g., Applied Behavioral Analysis (ABA) services for member with an Autism Spectrum Disorder (ASD) diagnosis
- Members as early as 6 months old through age 20 years can receive comprehensive dental services that are coordinated by Community Case Management Corporation (CCMC). Children from 6 months through age 20 can receive routine dental care. We make a referral to CCMC who will work with you and dental providers to coordinate dental care.

  This includes exams twice a year, X-rays, and preventive care and treatment. Benefits do not include orthodontic care.
- Transportation services are available (off-island transportation requires a prior authorization)
- Translation services are available at no cost
- Any services approved as medically necessary by the health plan

If you are pregnant or have just given birth, let us know as soon as possible. We can help your child get EPSDT services.

What are my preventive health services?

Regular visits to your primary care provider (PCP) are important. The following tables provide a list of preventive health guidelines for children, men and women. Talk to your PCP about any services that may be needed. You may need other services if you are at risk for any health problems.

Preventive health care for children*				
Services **Ages:**	**Birth to 2 years**	**3 to 6 years**	**7 to 12 years**	**13 to 20 years**
Tot to Teen health check or well-child exam				
Should include: Exam of child Medical history of child Weight and length/height measurement Age appropriate immunizations Discussion on your child's eating habits Developmental and behavioral screening Vision and hearing screens at the right age The doctor will talk to you about what to expect from your child Any referrals to special services or specialist for your child Health education or counseling	Birth < 1 month 1 month 2 months 4 months 6 months 9 months 12 months 15 months 18 months 24 months 30 months	Every year	Every year Depression screening starting at 11 years old Alcohol and drug use assessment starting at 11 years old Sexually transmitted infection (STI) and HIV screening starting at 11 years old	Every year

Preventive health care for children*				
Services **Ages:**	**Birth to 2 years**	**3 to 6 years**	**7 to 12 years**	**13 to 20 years**
Dental exams				
Oral health is essential to your child's overall health. Promote oral health for your child by taking your child to the dentist as early as **6 months**.	Take your child to the dentist every **6** months	Take your child to the dentist every **6** months	Take your child to the dentist every **6** months	Take your child to the dentist every **6** months
Immunizations				
Shots are important. Ask your child's PCP at every visit what shots are needed.	There is a series of shots that must be completed by 15 months checkup Ask your child's PCP at every visit what shots are needed	Ask your child's PCP at every visit what shots are needed	Ask your child's PCP at every visit what shots are needed	Ask your child's PCP at every visit what shots are needed
Screening tests				
Lead testing; Anemia **Other screening tests:** TB Cholesterol STD (Sexually Transmitted Disease)	Lead testing at **9–12** and **24** months; test for anemia at **9–12** months	Ask your child's PCP about any screening tests your child may need	Ask your child's PCP about any screening tests your child may need	Ask your child's PCP about any screening tests your child may need

*** These are guidelines for routine services. Talk to your child's PCP about any additional services they may need. They may need other services if they are at risk for certain health problems. This information is from the AAP – American Academy of Pediatrics.**

Preventive health care for men*				
Services **Ages:**	**18 to 30 years**	**31 to 50 years**	**51 to 64 years**	**65 years and older**
Annual exam				
Should include: Medical history Height and weight Age appropriate immunizations Discussion on eating habits Behavioral health screening Hearing screens Blood pressure checks Screening for alcohol or substance abuse Any referrals to specialist or special services you may need Health education or counseling	Every year	Every year	Every year	Every year
Immunizations				
Shots are important. Ask your doctor what shots are needed.	Ask your PCP at every visit about your shots	Ask your PCP at every visit about your shots	Ask your PCP at every visit about your shots	Ask your PCP at every visit about your shots

Preventive health care for men*				
Services **Ages:**	**18 to 30 years**	**31 to 50 years**	**51 to 64 years**	**65 years and older**
Cancer screenings				
Colorectal cancer, one of the following:				
1. Fecal Occult Blood Test		1. Every year starting at age 45	1. Every year	1. Every year
2. DNA based Colorectal Screening		2. Every 3 years starting at age 45	2. Every 3 years	2. Every 3 years
3. Sigmoidoscopy		3. Every 5 years starting at age 45	3. Every 4 years	3. Every 4 years
4. Colonoscopy		4. High Risk: Every 24 months. Non-High Risk: Every 10 years starting at 45.	4. High Risk: Every 24 months. Non-High Risk: Every 10 years.	4. High Risk: Every 24 months. Non-High Risk: Every 10 years.
5. CT Colonography		5. Every 5 years starting at age 45	5. Every 5 years	5. Every 5 years
Prostate cancer		If you are age 45 or older, talk to your PCP about being tested for prostate cancer	Talk to your PCP about being tested for prostate cancer	Talk to your PCP about being tested for prostate cancer

Preventive health care for men*				
Services **Ages:**	**18 to 30 years**	**31 to 50 years**	**51 to 64 years**	**65 years and older**
Cancer screenings (continued)				
Testicular cancer	Talk to your PCP about being tested for testicular cancer	Talk to your PCP about being tested for testicular cancer	Talk to your PCP about being tested for testicular cancer	Talk to your PCP about being tested for testicular cancer
Screening tests				
Tuberculosis screen Diabetes screen Screening for sexually transmitted diseases Serum cholesterol tests	Ask your PCP about any screening tests you may need	Ask your PCP about any screening tests you may need	Ask your PCP about any screening tests you may need	Ask your PCP about any screening tests you may need

*** These are guidelines for routine services. Talk to your PCP about any additional services you may need. You may need other services if you are at risk for certain health problems. This information is from the U.S. Preventive Services Task Force.**

Preventive health care for women*				
Services **Ages:**	**18 to 30 years**	**31 to 50 years**	**51 to 64 years**	**65 years and older**
Annual exam				
Should include: Medical history Height and weight Age appropriate immunizations Discussion on eating habits Behavioral health screening Hearing screens Blood pressure checks; Screening for alcohol or substance abuse Any referrals to specialist or special services you may need Health education or counseling	Every year	Every year	Every year	Every year
Immunizations				
Shots are important. Ask your doctor what shots are needed.	Ask your PCP at every visit about what shots you need	Ask your PCP at every visit about what shots you need	Ask your PCP at every visit about what shots you need	Ask your PCP at every visit about what shots you need

Preventive health care for women*				
Services Ages:	**18 to 30 years**	**31 to 50 years**	**51 to 64 years**	**65 years and older**
Cancer screenings				
Cervical cancer screen: 1. Cervical cytology 2. Cervical cytology/ human papillomavirus (HPV) co-testing 3. Cervical high-risk HPV (hrHPV) testing	 1. Every 3 years starting at age 21 2. Every 5 years starting at 30 3. Every 5 years starting at 30	 1. Every 3 years 2. Every 5 years 3. Every 5 years	 1. Every 3 years 2. Every 5 years 3. Every 5 years	Ask your PCP
Breast cancer	**Ages 18–40 years old:** High Risk: Mammogram upon physician recommenda-tion (for individuals with family history of breast cancer (i.e., mother or sister)).	Mammogram every 1 to 2 years starting at age 40	Mammogram every 1 to 2 years	Mammogram every 1 to 2 years

Preventive health care for women*				
Services **Ages:**	**18 to 30 years**	**31 to 50 years**	**51 to 64 years**	**65 years and older**
Cancer screenings (continued)				
Colorectal cancer, one of the following:				
1. Fecal Occult Blood Test		1. Every year starting at age 45	1. Every year	1. Every year
2. DNA based Colorectal		2. Every 3 years starting at age 45	2. Every 3 years	2. Every 3 years
3. Sigmoidoscopy		3. Every 5 years starting at age 45	3. Every 4 years	3. Every 4 years
4. Colonoscopy		4. High Risk: Every 24 months. Non-High Risk: Every 10 years starting at 45.	4. High Risk: Every 24 months. Non-High Risk: Every 10 years.	4. High Risk: Every 24 months. Non-High Risk: Every 10 years.
5. CT Colonography		5. Every 5 years starting at age 45	5. Every 5 years	5. Every 5 years
Other screening tests				
Tuberculosis screen Rubella screen Diabetes screen Serum cholesterol tests	Ask your PCP about any screening tests you may need	Ask your PCP about any screening tests you may need	Ask your PCP about any screening tests you may need	Ask your PCP about any screening tests you may need

*** These are guidelines for routine services. Talk to your PCP about any additional services you may need. You may need other services if you are at risk for certain health problems. This information is from the U.S. Preventive Services Task Force.**

Preventive health care for women*	
Services	**Ages: All women of childbearing age**
Gynecology/family planning	
Pap smear Pelvic exam Clinical breast exam Chlamydia screen Rubella screen Screening and counseling for HIV testing Sexually transmitted disease testing Sexual health education Information about contraception Pregnancy testing	Pap smear recommended starting at age 21. See your PCP or midwife when you become sexually active or by age 21. Then, see your PCP every year.
Prenatal care	
Pregnancy checkups Prenatal screen Medical history Behavioral health history Screening for alcohol or substance abuse Hāpai Mālama program	See your prenatal care provider or midwife during first trimester, or within 42 days of enrollment or as soon as you think you are pregnant. Then, visit your prenatal care provider or midwife every 4 weeks for the first and second trimester and every week during the last month or as instructed by your prenatal care provider or midwife. To learn more about what to expect during pregnancy, please visit our website at: myuhc.com/CommunityPlan.
Postpartum care	
Follow-up visit for mom after you deliver your baby Hāpai Mālama program	See your prenatal care provider or midwife between 7 to 84 days after giving birth.

*** These are guidelines for routine services. Talk to your PCP about any additional services you may need. You may need other services if you are at risk for certain health problems. This information is from the U.S. Preventive Services Task Force.**

Community Integration Services (CIS)

Community Integration Services (CIS) includes pre-tenancy supports and tenancy sustaining services that help support you to be a successful tenant in housing whether you own, rent or are leasing a home. Pre-tenancy supports help to identify your needs and preferences, assist you with the housing search process, and help arrange the details of your move into your new home. Tenancy sustaining services help you with independent living sustainability that includes tenant/landlord relationship.

Services are coordinated with the goal of providing collaborative and integrated services to promote and ensure self-sufficiency. This includes outreach to CIS Members requiring services who might not access these services without intervention due to language barriers, acuity of condition, dual diagnosis, physical/visual/hearing impairments, intellectual disability and/or lack of transportation.

CIS Members enrolled in the Community Care Services (CCS) behavioral health organization (BHO) will receive CIS services through the CCS program.

Referrals for CIS services

If you are a new Member to UnitedHealthcare Community Plan, a Health and Functional Assessment will be conducted to help us determine the types of services that you may need which includes housing assistance.

If you have been a Member for some time and need help with housing, you may contact us toll-free at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m. HST, Monday–Friday. You can also speak with your Health Coordinator (if you have one) about your housing needs. The Health Plan may also receive a referral on your behalf from a variety of sources such as family members, homeless services providers, other community-based organizations, and health care providers. Referrals can be called in by any of the sources listed above through the same toll-free number listed above. Once you contact us or when we receive a referral on your behalf, we will start the assessment process to determine your eligibility for housing assistance.

Qualifying criteria

Community Integration Services are available to members eighteen (18) years of age and older if the individual meets at least one of the following criteria **and** qualifying health conditions listed in the next section:

- Living in a place not meant for human habitation such as a car, park, train station, airport, camping ground, in an abandoned building, in an emergency shelter, or are leaving or exiting an institution where they are temporarily residing. Temporary housing includes congregate shelters, transitional housing, hotels and motels paid for by charitable organizations or by federal state or local government programs for low income members.
- Is living in public housing and at risk of eviction
- Member that may have received a written notification that their residence will be lost within twenty-one (21) days of the date of application for assistance but they do not have sufficient resources or support readily available to them such as, family, friends, church or other social support that can help them with immediate shelter or housing
- Member that has a history of frequent and/or lengthy stays in a nursing facility:
  - Frequent is defined as more than one stay in the past twelve (12) months
  - Lengthy is defined as sixty (60) or more consecutive or continuous days within an institutional care facility

Qualifying health conditions

- A mental health disorder which interferes with one or more major life activities, or
- Has been diagnosed with substance use disorder (SUD), or
- Chronic physical or complex health needs which interferes with daily life living activities.

Community Integration Services includes the following benefits:

Pre-tenancy services

- Identifying eligible individuals — Includes identification of housing preference (i.e., rental, owned, leased, one level or multiple levels), location, the number of household members, etc.
- Screening/assessments — Identify needs, strengths, motivations, barriers and resources. Identify level of functioning and assess entire family support system, including assistance with budgeting for housing and living expenses.
- Develop an individualized plan — Address identified barriers, short and long-term measurable goals, and establish how goals will be achieved and how concerns will be addressed.

- Connecting to Social Services — Assist the member with connecting to social services to help with obtaining documents, filling out and submitting applications for food and income including establishing credit, training to understand and meet obligations of tenancy, and finding and applying for housing necessary to support the member in meeting their medical needs.
- Participate in person-centered plan meetings at redetermination and/or conducting revision plan meetings as needed and provide supports and interventions as per the person-centered plan. Person-centered plan meetings include a team of family, friends, neighbors, employers, community members and health care professionals to help determine appropriate help for the member.

Tenancy sustaining services

- Service planning support and participation in person-centered plan meetings at redetermination and/or while during revision plan meetings, as needed
- Coordinating and linking the member to services and service providers including primary care and health homes, medical and behavioral health services including substance abuse treatment providers, including hospitals and emergency rooms, physical health providers, probation and parole, education, employment, volunteer supports, crisis services, end of life planning and other support groups and natural supports
- Assist member in applying for assistance that they may be entitled to including obtaining documentation, navigating and monitoring application and reauthorization or recertification process, and coordinating with the appropriate agency office
- Assistance in accessing support services such as individual and family counseling, support groups and natural supports so that the member can live independently
- Provide supports to assist the member develop independent living skills, such as skills coaching, financial counseling, and anger management
- Provide supports to assist the member in communicating with the landlord and/or property manager related to member's disability (if authorized and appropriate), accommodations needed and addressing emergency procedures involving the landlord and/or property manager
- Coordinate with the member to review, update and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers
- Connect member to training and resources that will assist the member in being a good tenant and achieving lease compliance, including ongoing support with activities related to household management

Community transition services

- Transitional case management services — Help arrange the move and transport personal possessions and furnishings to new home. Assess the new home and member's readiness for move-in by assisting the member in obtaining furniture and other needed household items (we will not pay for the cost of these personal items).
- Ensure housing is safe — We will pay for repairs or solution for issues related to mold or pest infestation to help address member's health condition (if these resources are not covered under any other program).
- Legal assistance — We will help connect you to expert community resources to help you address legal issues related to housing problems that may negatively impact your health, such as assistance with breaking a lease due to unhealthy living conditions.
- Housing payments — Assistance with a one-time payment for security deposit and/or first month's rent providing funding is not available through any other program. This payment assistance is available only once during enrollment with UnitedHealthcare QUEST Integration, except for state extraordinary circumstances such as a natural disaster.

Exclusions (not covered by UnitedHealthcare)

- Payment for document recovery and housing application fees
- Payment of ongoing rent or other room and board costs
- Capital costs related to the development of housing (i.e., purchase of plants and machinery, software, etc.)
- Expenses for ongoing regular utilities or other regular occurring bills
- Goods or services intended for leisure or recreation
- Services already covered by other state or federal programs
- Services to individuals in a correctional facility or institution for mental disease (IMD), other than services that meet the exception to the IMD inclusion
- Meals, welcome home supplies/baskets, mortgage payments, televisions, cable, telephones or telephone usage fees, recreation expenses, legal representation or payment for legal representation, furniture and commodities
- Room and board fees for residential treatment facilities
- Direct payment to members and/or family for CIS supported or related housing services
- One-time security deposit or first month's rent
- Landlord incentives, signing incentives, and mitigation for repairs
- State-wide or Continuity of Care (CoC) wide Risk Mitigation Fund for landlords
- Moving supports (moving costs and moving help if no company is available to hire)

Your rights under the CIS benefit

You have the right to:

- A lease, or legally enforceable rental agreement that will include the same responsibilities and protection from eviction under the landlord tenant law
- Privacy in your living unit, including a lock on your door, with only appropriate staff having keys to the doors, as needed for safety checks
- Choose roommates, if you choose to have one
- Decorate your living unit within the guidelines of your lease or rental agreement
- Control your schedule and choose the activities to participate in
- Have visitors
- Choose where you want to live to allow you easy access to community resources and independence in making life choices
- Give consent prior to making any changes to your rights and responsibilities
- Get information and be informed of the reason(s) as to why changes are being made to your rights and responsibilities
- Get written information or documentation about the changes that are being made

Call Member Services toll-free at **1-888-980-8728** (TTY users **711**) to be connected to your Health Coordinator, if assigned one or someone that will help you with any questions you may have about these services.

Value-added services

UnitedHealthcare offers extra benefits or value-added services to help keep you and your family healthy. These are in addition to the standard benefits available under QUEST Integration. Some services have limits and may be available only in certain areas or for a period of time. **For additional information about these extra benefits or value-added services, contact Member Services toll-free at 1-888-980-8728 (TTY users 711), 7:45 a.m.–4:30 p.m. HST, Monday–Friday for assistance.**

Traditional healing

These services are to help introduce, strengthen and support Native Hawaiian practices to help improve the health and well-being of members through physical activity, social support and cultural knowledge. Services include traditional methods of healing including lomilomi (traditional massage) and lāʻau lapaʻau (medicinal plant treatment). Program goal includes a positive impact on diabetes and pre-diabetes in a manner that resonates with the native Hawaiian population. These services are available only on the island of Oahu and in a certain area. Contact Members Services for additional information.

Community Transition program for the justice-involved

This program helps members who may have criminal records return to and stay in the community. Employing a trauma-informed and whole-person care approach, Health Coordinators and Community Health Workers partner with the Program's Justice Liaison to support members in navigating the healthcare and criminal legal systems. Together, they work with justice-involved members to meet their physical and behavioral health care needs and reach personal goals. Community Transitions also connects members to resources for assistance with issues such as housing, identification, and employment. Along the way, the Program takes a broad view of health and wellness, and promotes health equity and cultural humility in all member engagements. Contact Member Services for additional information.

Medical respite

Assistance for medically frail members that do not have a safe place or housing to go to upon discharge from the hospital, requiring temporary support. We provide assistance in accessing a medical respite bed, care management and linkage to additional community supports and programs. These services are subject to bed availability. Contact Member Services for additional information.

Integrated peer support services

These services are to help support persons who are in or seeking recovery from drugs, alcohol or mental illness by instilling hope, accessing treatment, seek preventive care, and explore vocational and educational goals. Services are delivered by a Peer Specialist who has similar life experiences and offers education, skill building, and an emphasis on member empowerment. Peer Support Services compliment the services delivered by the Health Coordination Team and providers and is a critical link to an integrated care approach. Integrated Peer Support Services are available to Medicaid members who are interested in additional recovery supports and are referred by their Health Coordination Team. Contact Member Services for additional information.

UnitedHealthcare On My Way™

UnitedHealthcare OMW™ (UnitedHealthcare On My Way) is a website that gives young adults that may be transitioning to adulthood, an effective and engaging online learning tool. It will help to prepare them to make a successful transition to independent living. The website teaches real-life skills in six areas, Money, Housing, Health, Employment, Transportation, and Education. The website is similar to a digital interactive game, that guides youth through things they need to know to get ready to live on their own. Youth earn points for taking action as they go through the activities. Members can get this learning tool at **uhcOMW.com**. There is no cost to members to use this website. Contact Member Services for additional information about the website or for assistance.

Special note: The same payment rules apply to these value-added services as outlined in the first paragraph of **page 150** under the section **Payment for services**. All Health Plan rules must be followed to prevent paying out-pocket for these services.

Non-covered services

Certain services and service categories are excluded from coverage under the UnitedHealthcare Community Plan QUEST Integration program. Even if excluded, upon request we will review a treatment or service for medical necessity. For a complete list of exclusions, contact Member Services toll-free at **1-888-980-8728** (TTY users **711**). Below is a list of services that are typically not covered but can be reviewed for medical necessity as well as services that are excluded or not covered by your plan.

Exceptions

Here is a list of services that are typically NOT covered under the QUEST Integration program, but can be reviewed upon request for medical necessity on a case-by-case basis:

- Services that are not medically necessary (as defined in Hawai‘i statute)
- Services that are experimental or investigative
- Non-emergency services provided out-of-state that have not been authorized in advance. (Post-stabilization services after emergency admission are covered.)
- Services from a non-participating provider if an in-network provider is available
- Surgery for your appearance, except authorized reconstructive surgery
- Routine, restorative and cosmetic dental services, excluding authorized medical procedures related to dental work
- Reversal of sterilization
- Artificial insemination, in-vitro fertilization or any other treatment to create a pregnancy
- Treatment of impotence
- Hysterectomies performed primarily for making a member incapable of reproducing
- Hysterectomies performed for cancer prophylaxis when not medically indicated
- Physical exams or other services for work
- Personal hygiene, luxury, or convenience items
- Foot care for comfort or appearance, like flat feet, corns, calluses, toenails
- Drugs for:
  - Hair growth
  - Cosmetics
  - Controlling your appetite
  - Treatment of impotence
  - Treatment of infertility
  - Erectile dysfunction or similar “lifestyle” products
- Drugs that the FDA (Food and Drug Administration) says are:
  - DESI — this means that research says they are not effective
  - LTE — this means that research says they are less than effective
  - IRS — this means that the drugs are identical, related, or similar to LTE drugs
- Environmental modifications or home adaptations that solely add to the square footage of the home, are of general utility, or are in excess of standard modification costs
- Laboratory and diagnostic tests that are experimental, investigational or unproven

- IgG4 testing and storing, preparation and transfer of oocytes for invitro fertilization
- Certain vision services such as orthoptic training, prescription fees, progress exams, radial keratotomy, visual training, and Lasik procedure
- Ultrasound for gender determination
- Services that have been denied by another payer typically covered by the other payer but denied due to lack of approval or failure to follow the other payer's prior authorization and appeal processes
- Chiropractic, acupuncture, or massage therapy

Exclusions

- Any services outside of the United States or out of the country
- Autopsy or necropsy
- Any services if the member is in local, state or federal jail or prison
- Services covered by another payer, such as Medicare
- UnitedHealthcare Community Plan QUEST Integration Medicaid hospice services provided to members receiving Medicare hospice services that is duplicative of Medicare hospice benefits. Examples include personal care and homemaker service. This is only covered when the service need is not related to the hospice diagnosis.
- UnitedHealthcare Community Plan QUEST Integration Medicaid home health services when they are already covered by Medicare home health benefits (this exclusion applies only to members who also have Medicare)
- Services that are covered by Workers' Compensation insurance
- Services not allowed by the State of Hawai'i Medicaid Program
- Services that are carved out or covered by the DHS or other State agencies such as the:
  - Community Care Services (CCS) program
  - Child and Adolescent Mental Health Division (CAMHD) through the Support for Emotional and Behavioral Development (SEBD) program
  - Intellectual and Development Disabilities (I/DD) services
  - School-based services (these are services that are provided while the individual is in school or provided in a school setting)
  - Zero to Three services (early intervention program)
  - State of Hawai'i Organ and Tissue Transplant (SHOTT) program
  - Abortion or Intentional Termination of Pregnancies (ITOPS)
  - End of Life Care option (Our Care, Our Choice Act)

See next section for additional information on the services that are carved out to the DHS or other State agencies.

Services you may get from the DHS or other State agencies

Some services are not covered under QUEST Integration. You may be able to get them from the DHS or other State agencies.

The following services that are listed in this page and within the next 6 pages are carved out to the DHS or other State agencies:

- Comprehensive behavioral health services for adults
- Additional behavioral health services for members under 21
- Intellectual and Developmental Disabilities (I/DD) services
- Dental services
- School-based services
- Cleft and craniofacial services
- Zero to Three services (early intervention program)
- Women, Infants and Children (WIC) program
- Transportation to services not provided by our QUEST Integration plan
- State of Hawai‘i Organ and Tissue Transplant (SHOTT) program
- Hawai‘i CARES
- Abortions or Intentional Termination of Pregnancies (ITOPs)
- End of life care option (Our Care, Our Choice Act)

Comprehensive behavioral health services for adults

Members eighteen (18) years of age or older with a diagnosis of severe mental illness (SMI) or severe and persistent mental illness (SPMI) may be eligible for enrollment into the Community Care Services program (CCS). This is a specialized behavioral health services program.

Members between ages eighteen (18) and twenty (20) years of age have the option to receive their behavioral health services either through the CCS program or the Child and Adolescent Mental Health Division’s (CAMHD) Support for Emotional and Behavioral Development (SEBD) program. These services are carved out to the DHS.

The CCS program includes regular behavioral health services and additional services to help you. The additional services include, for example:

- Intensive case management
- Partial hospitalization
- Psychosocial rehabilitation/clubhouse
- Therapeutic living supports
- Individual and group support programs

We will work with you, your providers, the DHS and the CCS program for enrollment in the CCS program. If you enroll in the CCS program, we will continue to provide you with QUEST Integration covered services. You will get your behavioral health services from the CCS program. We will coordinate care with the CCS program.

Additional behavioral health services – for members under 21

Members under twenty one (21) years old with a diagnosis of serious emotional behavioral disorders are eligible for additional behavioral health services. These services are offered by the Department of Health, Child and Adolescent Mental Health Division (CAMHD). The program is offered through the Support for Emotional and Behavioral Development (SEBD) program.

You get CAMHD services through their family centers. These are:

Family guidance center	Location	Phone
Central O‘ahu	Pearl City	**808-453-5900**
Family Court Liaison Branch	Kailua	**808-266-9922**
Honolulu	Honolulu	**808-733-9393**
Leeward O‘ahu	Kapolei	**808-692-7700**
Windward Kaneohe	Kaneohe	**808-233-3770**
Hawai‘i **Hilo** **Waimea**	 Hilo Waimea	 **808-933-0610** **808-887-8100**
Kaua‘i	Lihue	**808-274-3883**
Maui	Wailuku	**808-243-1252**

Family guidance center	Location	Phone
Lahaina	Lahaina	**808-243-1252**
Moloka‘i	Kaunakakai	**808-553-7878**
Lana‘i	Lana‘i City	**808-243-1252**

Intellectual and Developmental Disabilities (I/DD) services

The I/DD program serves people with mental or developmental disabilities. The services are given by contracted providers. These include Home and Community Based Services (HCBS) such as housing, living skills, home chores, and personal alarm system. They also include behavioral help, nursing and personal assistance and habilitation.

The I/DD Case Manager is the primary Case Manager. The I/DD Case Manager works with your Health Coordinator. The UnitedHealthcare Health Coordination Team identifies and makes appropriate referrals to the Department of Health, Child and Adolescent Mental Health Division (CAMHD), Adult Mental Health Division (AMHD) and the Development Disability Division (DDD) for members that meet certain conditions. Your Health Coordinator will coordinate medically necessary services covered by UnitedHealthcare including transitioning of care in and out of the I/DD program.

Contact I/DD at **808-733-9172** (O‘ahu), **808-241-3406** (Kaua‘i), **808-243-4625** (Maui, Lāna‘i, and Moloka‘i), **808-974-4280** (East Hawai‘i), **808-887-6064** (Waimea), or **808-327-6212** (Kona). Or call your Health Coordinator for assistance.

Dental services

Adults and children: Emergency and routine dental services are not covered by UnitedHealthcare Community Plan QUEST Integration program but they are covered by the Department of Human Services (DHS) Medicaid Fee For Service program.

Present your Medicaid ID card that you received from the DHS when seeing the dentist for these dental services. Your Medicaid ID card is different from your UnitedHealthcare Community Plan QUEST Integration member ID card that we sent you.

Members under age 21: Individuals under age twenty-one (21) will receive their dental benefits under Early and Periodic Screening Diagnosis and Treatment (EPSDT).

Adults: Dental Services are now available to eligible members over the age of 21 and continues for those under the age of 21. Covered services include the following:

(Some limitations and prior authorization may apply.)

Services	Description and limitation
Preventative Services	• Comprehensive oral evaluation — Once every 5 years • Periodic screening examinations — 2 per year • Prophylaxis — 2 per year • Topical fluoride or fluoride varnish — 2 per year
Diagnostic and Radiology Services	• Bitewing X-rays — 2 per year • Full series X-rays — 1 every 5 years • Periapical X-rays • Biopsies of oral tissue
Endodontic Therapy Services	• Root canal therapy on permanent molars
Restorative Services	• Amalgams on primary and permanent posterior teeth • Composites on anterior and posterior teeth • Pin and/or post reinforcement • Cast cores • Recement inlays and crowns • Stainless steel crowns
Oral Surgery	
Periodontal Therapy Services	• Scaling and root planning — one every 24 months
Prosthodontic Services	• Complete upper and lower dentures — One every 5 years • Partial dentures — One every 5 years • Denture relines — One every 2 years • Repairs
Emergency and Palliative Treatment	• Gingivectomy, for gingival hyperplasia • Other medically necessary emergency dental services

Call Community Case Management Corporation (CCMC) at 792-1070 or toll-free at 1-888-792-1070. CCMC can explain the covered dental benefits and help you find a dentist near you. CCMC also assists with air/ground transportation for dental appointments for members that may need to travel to another island for dental treatment that may not be available on their island of residence. All travel to the neighbor islands must be first approved by CCMC.

Present your Medicaid ID card that you received from the DHS when seeing the dentist for these dental services.

Your Medicaid ID card is different from your UnitedHealthcare Community Plan QUEST Integration member ID card that we sent you.

Note: Members with other coverage that is primary to Medicaid with dental benefits (i.e., Medicare Advantage or Commercial plan, etc.), please check with your primary insurance plan on dental benefits to ensure appropriate benefit coordination with the DHS dental coverage.

School-based services

The Department of Education offers services students need. It promotes caring relationships among students, teachers, families, and agencies. It seeks to ensure timely intervention. This is to provide optimum classroom climate, family involvement, and specialized help. DOH also provides transportation.

Contact them at **808-784-6200 (all islands)**.

You may also call your Health Coordinator for assistance, if you are assigned one.

Cleft and craniofacial services

Care is provided in coordination with the Kapiʻolani Cleft and Craniofacial Clinic and Department of Health/Family Services Division/Children with Special Health Needs (CSHN) Branch. The clinic provides the services of pediatric dentists, orthodontists, oral surgeons, otorhinolaryngologists, pediatric psychiatrists, audiologists, speech and feeding specialists, neonatologists, geneticists, and genetic counselors.

To learn more about the services provided through the Kapiʻolani Cleft and Craniofacial Clinic and Department of Health/Family Services Division/Children with Special Health Needs (CSHN) Branch, you may contact the Clinic at **808-983-8500**, choose Option 1.

Zero to Three services (early intervention program)

Zero to Three helps children with a condition that may result in developmental delay. Services include screening, assessment, home visitation and transportation. If you feel your child has delays, call H-KISS. (H-KISS means Hawai'i Keiki Information Service System.) H-KISS is the central point for referrals. Call **1-800-235-5477** or **594-0066** (O'ahu).

Referrals may be from any source. This includes hospitals, doctors, parents, day care, education or public agencies, or other providers.

The Department of Health coordinates services with community agencies.

Women, Infants and Children (WIC) program

WIC is a special nutrition program for women, infants and children that provides free:

- Nutritious food such as milk, eggs, cereal, etc.
- Education on nutrition best for your family
- Support for mothers related to breastfeeding
- Health care referrals

UnitedHealthcare will cover the cost of specialty formula when it is determined to be medically necessary. If you are pregnant, talk to your doctor about completing a WIC application or call WIC at **586-8175** (O'ahu) and **1-888-820-6425** (Neighbor Islands).

Transportation to services not provided by our QUEST Integration plan

Some transportation may be available for medical and dental appointments. Call CCMC at **1-808-792-1070** (O'ahu) and toll-free at **1-888-792-1070** (for Neighbor Islands) for questions about transport. For information about transport for QUEST Integration covered benefits, see section on **Transportation**.

State of Hawai‘i Organ and Tissue Transplant (SHOTT) program

The Department of Human Services provides transplants that are not experimental or investigational and not covered by QUEST Integration. The SHOTT program covers adults and children for liver, heart, heart-lung, lung, kidney, kidney-pancreas, and allogenic and autologous bone marrow transplants. Children will be covered for transplants of the small bowel with or without liver. Children and adults must meet medical criteria as determined by the DHS and the SHOTT program contractor. For information, contact Member Services toll-free at **1-888-980-8728** (TTY users **711**).

While the SHOTT program is responsible for transplant services that are listed above, there are situations in which the Health Plan will be responsible for kidney transplants for Members that have Medicare or commercial insurance coverage as primary to QUEST Integration.

Kidney transplants for adults (21 years old and older) with Medicare or other insurance coverage:

- If you need or will have only a kidney transplant, we will cover your kidney transplant after we coordinate payment with your primary insurance carrier
- If you need or have a kidney transplant plus another type of transplant (for example, a kidney transplant plus a pancreas transplant) your primary or other insurance payer will pay first for both transplants and then the SHOTT Program will pay last. The SHOTT Program will coordinate payment with your primary insurance carrier.

Kidney transplants for children (under 21 years old) with Medicare or other insurance coverage:

- We will refer the case to the SHOTT Program for review and they will let us know if they will cover the service. We will coordinate care with your doctor(s). If the SHOTT Program accepts your case then they will coordinate payment with your primary insurance carrier.
- If the SHOTT Program does not accept your case then we will coordinate payment with your primary insurance carrier

Hawai‘i CARES

Hawai‘i CARES is a free, 24/7 coordination center for substance use, mental health and crisis intervention. **Call from any island: 808-832-3100 or toll-free at 800-753-6879.**

The Hawaii CARES program is a statewide initiative of the Hawaii State Department of Health to increase access to support for individuals needing substance abuse treatment. The Hawai‘i CARES staff provides supportive counseling, screening for urgent or emergent mental health or substance use needs, and recommendations for behavioral health assessments and services and crisis intervention.

Abortions or Intentional Termination of Pregnancies (ITOPs)

Abortions or Intentional terminations of pregnancy (ITOP) are not covered by UnitedHealthcare QUEST Integration. They are covered by the Med-QUEST Division (MQD). You will need authorization. Your provider shall contact MQD's Clinical Standards Office (CSO), on ITOP requests. MQD will cover all procedures, medications (including abortion pills), transportation, meals and lodging associated with ITOPs. MQD can also arrange for transportation.

Your provider will bill the MQD's Fiscal Agent for services covered by the MQD. If you need additional information or have questions, contact Member Services toll-free at **1-888-980-8728** (TTY users **711**) for assistance.

UnitedHealthcare QUEST Integration will cover only those treatments for medical complications occurring because of an elective termination and treatments for spontaneous, incomplete, or threatened terminations as well as ectopic pregnancies. Your provider will bill us only for these services.

End of life care option (Our Care, Our Choice Act)

These services are covered by the Department of Human Services (DHS). Services are available to members with a terminal illness and are expected to live no more than six (6) months and voluntarily requests for medical aid-in-dying medication. Covered services include physicians, consulting and counseling provider visits and related medications. Talk to your doctor on how you can receive these services. You can also call our Member Services toll-free **1-888-980-8728** (TTY users **711**) if you have any questions about these services.

Other Medicaid covered services that are not provided by UnitedHealthcare

- Services that are provided by another state, county or federal program
- Any services otherwise provided to a member by a local, state or federal agency or facility
- Behavioral Health Service for:
  - Members whose behavioral diagnostic, treatment or rehabilitative services are not determined to be medically necessary by the health plan
  - Members who have been criminally committed for evaluation or treatment in an inpatient setting under the provisions of Chapter 706, HRS

Additional health improvement programs offered

Health Coordination/disease management and population health management

Our Health Coordinators can help you get care to manage your disease or medical condition. They are experienced nurses and social workers. They understand your medical issues. They work with you and your providers to help you get the care you need.

Our Health Coordinators can help you:

- Find a primary care provider, specialist, or urgent care facility
- Make appointments
- Assist with scheduling medical transportation
- Arrange for medical supplies and home health care, if needed
- Learn how to take care of yourself
- Find community resources and support
- Give you information and resources to quit smoking
- Help you get information translated to a language you understand

We have the following prevention, health promotion, and disease management programs

Wellness Initiative — A series of monthly health topics presented in a live virtual environment to help you stay healthy and manage conditions.

Asthma Program — A program for members that have asthma and want to learn more.

Diabetes Program — A program for members that have diabetes or pre-diabetes and want to learn more.

Weight Management — A program for members that want to learn more about managing their weight.

Hāpai Mālama — A maternity support program for pregnant and postpartum women to help them learn more about healthy pregnancy.

If you want to know more or join one of the programs, call Member Services toll-free at **1-888-980-8728** (TTY users **711**).

Hāpai Mālama program

If you are thinking of having a baby, or think you are pregnant, call Member Services toll-free at **1-888-980-8728** (TTY users **711**).

A Hāpai Mālama staff member will:

- Help you find the right provider
- Find care that supports your cultural beliefs, values, and preferences
- Get a breast pump
- Provide health care support if you have special health care needs
- Help you schedule prenatal and postpartum visits and transportation if needed
- Give you information on good eating habits and health practices, like attending all your prenatal appointments and getting regular dental checkups
- Help you find community resources that you may need during and after your pregnancy
- Check in with you during your pregnancy and after delivery to answer any questions, help you schedule appointments and transportation if needed

Let us know if you are pregnant

Call and sign up for our Hāpai Mālama Program toll-free at **1-888-980-8728** (TTY users **711**).

Care during pregnancy and after delivery

We want you to have a healthy pregnancy and a healthy baby. Getting care from an OB/GYN and starting those visits early in your pregnancy is an important step. Contact the health plan for help in scheduling your first prenatal visit with an OB/GYN once you find out you are pregnant, or think you may be pregnant. Your first pregnancy checkup should take place during the first 3 months of your pregnancy or within 42 days of joining UnitedHealthcare.

Your pregnancy care continues even after your baby is born. Be sure to schedule your postpartum visit with your OB/GYN 7 to 84 days after you deliver. Contact Member Services or your Hāpai Mālama coordinator toll-free at **1-888-980-8728** (TTY users **711**) to help you schedule an appointment.

Inpatient and outpatient substance use treatment is also available for pregnant and parenting women and their children.

Neonatal services

We want your baby to be healthy. Sometimes extra care is needed after the baby is born. We have resources and supports to offer you and may call you directly or you can call us anytime toll-free at **1-888-980-8728** (TTY users **711**) to reach an experienced nurse or social worker to help:

- Answer questions about your delivery and newborn care
- Give information to help you make decisions
- Work with your providers to make sure you and your baby get the care you need
- Help you plan for bringing your baby home, including any home health care needs
- Put you in touch with community resources and services
- Enroll you into Health Coordination
- Review your benefits to make sure you have all the resources

Healthy First Steps rewards program

Healthy First Steps is a free online wellness program for pregnant women and moms who have given birth within the last 15 months. This program offers rewards for obtaining your prenatal, postpartum and child's well-baby care. This program can help keep track of your appointments. You can also earn as many as 8 rewards of your choosing. Rewards include a diaper bag or Old Navy gift card, a nursing cover or teething rattle, a first aid kit or tabletop toy, a childproofing kit or puzzles and books among other rewards to support your well-being and your child/children's development. Sign up for Healthy First Steps at **UHCHealthyFirstSteps.com** and start earning rewards.

Note — The Healthy First Steps rewards program will end on 12/30/2023. See next section for the new Babyscripts™ Program Rewards that will begin 1/1/2024.

Incentive	Completed action	Option 1	Option 2	Value
1	Baby Blocks enrollment	Diaper bag	Old Navy gift card	$10
2	24-week prenatal visit	Nursing cover	Teething rattle with mirror	$10
3	32-week prenatal visit	First-aid kit	Tabletop toy	$10
4	Birth	Digital thermometer	Rubber duck bath thermometer	$10
5	Postpartum visit	Car seat cover	Old Navy gift card	$10
6	6-month well-child visit	Dental care kit	Baby feeding kit	$10
7	Lead screening	Childproofing kit	Children's book	$10
8	15-month well-child visit	Puzzle	Bath accessories for mother	$10

Babyscripts™ Program rewards – Effective 1/1/2024

The Babyscripts™ Program provides daily education on important topics that are specific to your stage of pregnancy, appointment reminders, track your weight and learn about nutrition and healthy habits during and after your pregnancy. You can earn up to three (3) Walmart eGift cards through the Babyscripts™ Program. Earn your first reward by enrolling in the Babyscripts™ Program. Earn your second reward by completing your first Prenatal visit with your doctor. Earn your third reward by completing your first Postpartum visit with your doctor. Follow the instructions within the Babyscripts myJourney app on how to log your first Prenatal/Postpartum visits information.

Please note: Rewards options may be subject to change and we will notify you in the future through various methods (i.e., Member Handbook, website, HealthTalk (member newsletter) or written communication by mail or postcard).

Incentive	Completed action	Value
1	Babyscripts enrollment	$30
2	Prenatal visit	$30
3	Postpartum visit	$30

To sign up for the Babyscripts™ Program, visit the Apple App Store® or Google Play™ store on your smartphone. Download the Babyscripts myJourney app. If you have questions, call Member Services toll free at **1-888-980-8728**, TTY **711**, 7:45 a.m.–4:30 p.m. HST, Monday–Friday, and ask to be connected to our **Hāpai Mālama** team for assistance.

Learn more

Watch a short video about getting started with UnitedHealthcare Community Plan on the internet by going to **https://www.uhccommunityplan.com/MemberLanding/OB/OBLand/HI**.

Additional information about UnitedHealthcare Community Plan

If you want to know more about us, such as operations or utilization policies, contact **Member Services toll-free at 1-888-980-8728** (TTY users **711**).

UnitedHealthcare Community Plan works with your doctors to make sure that you are getting the right care at the right time. Sometimes we will offer your doctors an incentive or bonus. We do this to help them help you keep on track with your appointments throughout the year.

UnitedHealthcare Community Plan follows the DHS requirement for value-based purchasing. This links a provider's reimbursement to improved performance and aligning payment with the quality of care they give to our members. This form of payment helps health care providers be accountable for access, quality of care and cost that they provide.

What if I need care immediately?

If you have an emergency, go immediately to the Emergency Room (ER) at the nearest hospital. If you need help getting to the ER fast, **call 911**. If you need care today but it is not an emergency, you can choose an Urgent Care Clinic or you can call your PCP for an urgent appointment or call NurseLine to speak to our nurses who are available anytime free of charge. You do not need a prior authorization to go the Emergency Room or Urgent Care Clinic.

You can also connect to **UHCDoctorChat.com** to see or video chat with one of our doctors who are available anytime free of charge.

Emergency care

If you have an emergency, go immediately to the Emergency Room (ER) at the nearest hospital or other setting that is appropriate for emergency care. If you need help getting to the ER fast, **call 911**. You do not need approval from UnitedHealthcare Community Plan or your doctor. You can expect to be seen within an hour to determine the extent of your illness or injury. Call your PCP for follow-up care as soon as you can after getting emergency care. UnitedHealthcare covers services provided in the emergency room including initial screening examinations to determine whether an emergency medical condition exists. UnitedHealthcare will not retroactively deny payment for emergency screening examinations because the condition turned out to be non-emergency in nature. UnitedHealthcare covers and pays for emergency services regardless if the provider that rendered the services is out-of-network.

What is an emergency?

An Emergency Medical Condition is one with sudden, severe symptoms that without immediate care could result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- Serious harm to self or others due to alcohol or drug abuse
- Injury to self or bodily harm to others
- In the case of a pregnant woman, serious jeopardy to the woman or her unborn child

If you have an emergency, call 911 for help, or go to the nearest emergency room or hospital so that you can be seen.

Some examples of emergencies are:

- Severe pain
- Convulsions
- Unconsciousness
- Severe or unusual bleeding
- A serious accident
- A suspected heart attack or stroke
- With a pregnant woman, having contractions

Here are some examples of what is not generally an emergency:

- Colds and flu
- Headaches
- Sore throats
- Bruises or minor cuts
- Rashes

Where do I go if there is an emergency?

You can use **any** hospital, other appropriate healthcare setting, or provider for emergency services. If you have to, you can go to a hospital or provider that is not in the network. You do not need approval from UnitedHealthcare Community Plan or your doctor.

In any emergency, **dial 911** or visit your nearest hospital or other provider for immediate assistance.

Below is a sample list of emergency facilities.

This sample list includes emergency facilities within the State of Hawai‘i regardless of their participating status with UnitedHealthcare Community Plan. Please note that this list may have changed as of when this Member Handbook was printed or updated. You can find a current list of participating emergency facilities online at **myuhc.com/CommunityPlan**. You may also call **Member Services toll-free at 1-888-980-8728** (TTY users **711**) for a current list of emergency facilities near you. You can get emergency care as well as stabilization services in any of these emergency facilities. **You do not need a prior authorization to get services from any emergency facility.**

Emergency facility	City	Phone	Address
The Island of Hawai‘i			
Hale Ho‘ola Hamakua	Honokaa	808-932-4100	45-547 Plumeria Street Honokaa, HI 96727
Hilo Medical Center	Hilo	808-932-3000	1190 Waianuenue Avenue Hilo, HI 96720
Ka‘u Hospital	Pahala	808-932-4200	1 Kamani Street Pahala, HI 96777
Kohala Hospital	Kapaau	808-889-6211	54-383 Hospital Road Kapaau, HI 96755
Kona Community Hospital	Kealakekua	808-322-9311	79-1019 Haukapila Street Kealakekua, HI 96750
The Island of Hawai‘i (continued)			

Emergency facility	City	Phone	Address
North Hawai‘i Community Hospital	Kamuela	808-885-4444	67-1125 Mamalahoa Highway 67 Kamuela, HI 96743
The Island of Kaua‘i			
Samuel Mahelona Memorial Hospital	Kapa‘a	808-822-4961	4800 Kawaihau Road Kapa‘a, HI 96746
Kaua‘i Veterans Memorial Hospital	Waimea	808-338-9431	4643 Waimea Canyon Drive Waimea, Hi 96796
Wilcox Memorial Hospital	Lihu‘e	808-245-1100	3-3420 Kuhio Highway Lihu‘e, HI 96766
The Island of Lana‘i			
Lana‘i Community Hospital	Lana‘i City	808-565-8450	628 7th Street Lana‘i City, HI 96763
The Island of Maui			
Kula Hospital	Kula	808-878-1221	100 Keokea Place Kula, HI 96790
Maui Memorial Medical Center	Wailuku	808-244-9056	221 Mahalani Street Wailuku, HI 96793
The Island of Moloka‘i			
Moloka‘i General Hospital	Kaunakakai	808-553-5331	280 Home Olu Place Kaunakakai, HI 96748
The Island of O‘ahu			
Adventist Health Castle	Kailua	808-263-5500	640 Ulukahiki Street Kailua, HI 96734
Kahuku Medical Center	Kahuku	808-293-9221	56-117 Pualalea Street Kahuku, HI 96731
The Island of O‘ahu (continued)			

Emergency facility	City	Phone	Address
Kaiser Permanente	Honolulu	808-432-0000	3288 Moanalua Road Honolulu, HI 96819
Kapiolani Medical Center for Women & Children	Honolulu	808-983-6000	1319 Punahou Street Honolulu, HI 96826
Kuakini Medical Center	Honolulu	808-531-3511	347 N Kuakini Street Honolulu, HI 96817
Pali Momi Medical Center	Aiea	808-486-6000	98-1079 Moanalua Road Aiea, HI 96701
Straub Clinic and Hospital	Honolulu	808-522-4000	888 S. King Street Honolulu, HI 96813
The Queen's Medical Center	Honolulu	808-691-1000	1301 Punchbowl Street Honolulu, HI 96813
The Queen's Medical Center West	Ewa Beach	808-691-3000	91-2141 Fort Weaver Road Ewa Beach, HI 96706
Tripler Emergency Room	Honolulu	808-433-6661	1 Jarrett White Road Tripler Army Medical Center HI 96859
Wahiawa General Hospital	Wahiawa	808-621-8411	128 Lehua Street Wahiawa, HI 96786
Waianae Coast Comprehensive Health Center	Waianae	808-697-3300	86-260 Farrington Highway Waianae, HI 96792

For non-urgent symptoms, an option for immediate answers is our NurseLine. NurseLine lets you speak with a registered nurse 24 hours per day, 7 days per week. The nurses have an average of 15 years of clinical experience. They use trusted, doctor-approved information to help you make the right decisions. The nurses can help you with:

- Minor injuries
- Common illnesses
- Self-care tips and treatment options
- Recent diagnoses and chronic conditions
- Choosing appropriate medical care
- Illness prevention
- Nutrition and fitness
- Questions to ask your doctor
- How to take medication safely
- Men's, women's and children's health
- And more

Call NurseLine toll-free at **1-888-980-8728** (TTY users **711**). Refer to **page 48** for additional information for NurseLine.

You can also connect to **UHCDoctorChat.com** to speak to or see one of our doctors anytime and anywhere. Our doctors can treat common conditions such as:

- Rashes, allergic reactions
- Cold/flu, ear aches, coughs, fevers, sore throat
- Diarrhea/constipation
- Headache, back and abdominal pain
- Animal/insect bites
- Nausea, vomiting, stomach pain
- Pink eye
- Urinary problems/UTI
- Sports injuries, burns, heat-related illness
- And many more

Connect with **UHCDoctorChat.com** to see or video chat with one of our doctors. Refer to **page 49** for additional information for UHC Doctor Chat.

What is post-stabilization care?

Post-stabilization care is covered service you get after emergency care to keep your condition stable. This includes services provided by an out-of-network provider. These services are usually provided through an emergency facility or hospital. Refer to **page 127** for a list of emergency facilities.

Urgent Care

Urgent Care is not emergency care. It is care that is needed sooner than a normal appointment (one calendar day). You do not need a prior authorization to go to an urgent care clinic or facility. You should first call your PCP or doctor for an appointment before going to an urgent care clinic or facility. Urgent Care should not be used for follow-up care. Call your PCP if you have a medical problem that is not an emergency or to schedule an appointment for follow-up care.

For these conditions, contact your PCP:

- Fever
- Infections
- Symptoms of cold or flu

The following is a sample list of Urgent Care Centers or Facilities that provide extended hours or after-hours care within the State of Hawai‘i regardless of their participating status with UnitedHealthcare Community Plan. Please note that this list may have changed as of when this Member Handbook was last updated or printed. You can find a current list of participating Urgent Care Centers online at **myuhc.com/CommunityPlan**. You may also call **Member Services toll-free at 1-888-980-8728** (TTY users **711**) for a current list of urgent care facilities near you.

Urgent Care locations — Neighbor islands — Asterisk (*) indicates clinics with extended hours

Urgent Care center	City	Phone	Address
The Island of Hawai‘i			
Aberco Medical Access (Kauka Express Urgent Care)	Hilo	808-981-1700	2100 Kanoelehua Avenue, #209 Hilo, HI 96720
Aloha Kona Urgent Care	Kona	808-365-2297	75-5995 Kuakini Highway Suite 213 Kailua Kona, HI 96740
Hilo Urgent Care Center	Hilo	808-969-3051	670 Kekuanaoa Street Hilo, HI 96720

Urgent Care center	City	Phone	Address
Hilo Urgent Care Center	Kea‘au	808-966-7942	16-590 Old Volcano Road Keaau, HI 96749
The Island of Hawai‘i (continued)			
Keauhou Urgent Care Center	Kona	808-322-2544	78-6831 Alii Drive, Suite 418 Kailua Kona, HI 96740
Puna Community Medical Center	Pahoa	808-930-6001	15-2662 Pahoa Village Road Suite 303-306 Pahoa, HI 96778
Urgent Care of Kona	Kona	808-327-4357	77-311 Sunset Drive Kailua Kona, HI 96740
Waimea Urgent Care	Kamuela	808-885-0660	65-1230 Mamalahoa Highway Suite A10 Kamuela, HI 96743
The Island of Kaua‘i			
Hale Le‘a Family Medicine and Urgent Care	Kilauea	808-828-2885	2460 Oka Street Kilauea, HI 96754
Kaua‘i Urgent Care	Lihue	808-245-1532	4484 Pahee Street Lihue, HI 96766
Makana North Shore Urgent Care	Princeville	808-320-7300	4488 Hanalei Plantation Road Princeville, HI 96722-5462
Poipu Mobile Urgent Care	Koloa	808-652-7021	2585 Waho Street Koloa, HI 96756
Urgent Care at Poipu/ The Clinic at Poipu	Koloa	808-742-0999	2829 Ala Kalanikaumaka Suite B201 Koloa, HI 96722
The Island of Maui			

Urgent Care center	City	Phone	Address
Doctors On Call – Maui's Urgent Care	Kahului	808-667-7676	22 Hana Highway Kahului, HI 96732
The Island of Maui (continued)			
Doctors On Call – Maui's Urgent Care	Lahaina	808-667-7676	3350 Lower Honoapiilani Road Suite 211 Lahaina, HI 96761
Doctors On Call – Maui's Urgent Care	Maui Island	808-439-3911	Telemedicine Services Call the phone number listed to the left to start a visit with a doctor
Kihei-Wailea Medical Center*	Kihei	808-874-8100	221 Piikea Avenue, Suite A Kihei, HI 96753
Maui Medical Group*	Kahului	808-871-1730	110 East Kaahumanu Avenue Kahului, HI 96732
Maui Medical Group*	Kihei	808-270-1528	2349 South Kihei Road, Unit D Kihei, HI 96753
Maui Medical Group*	Lahaina	808-661-0051	130 Prison Street Lahaina, HI 96761
Maui Medical Group*	Pukalani	808-573-6200	55 Pukalani Street Pukalani, HI 96768
Maui Medical Group*	Wailuku	808-242-6464	2180 Main Street Wailuku, HI 96793
Minit Medical Urgent Care	Kahului	808-667-6161	270 Dairy Road, Suite 239 Kahului, HI 96732
Minit Medical Urgent Care	Kihei	808-667-6161	1325 South Kihei Road, Suite 103 Kihei, HI 96753
Minit Medical Urgent Care	Lahaina	808-667-6161	305 Keaw Street, Suite 507 Lahaina, HI 96761

Urgent Care center	City	Phone	Address
Urgent Care West Maui	Lahaina	808-667-9721	2580 Kekaa Drive, Suite 111 Lahaina, HI 96761
The Island of O‘ahu			
Access Medical Clinics Urgent Care	Ewa Beach	808-685-0330	91 1401 Fort Weaver Road Ewa Beach, HI 96706
Access Medical Clinics Urgent Care	Mililani	808-627-0330	95-1249 Meheula Parkway Mililani, HI 96789
All Access Ortho	Honolulu	808-356-5699	1401 South Beretania Street Suite 102 Honolulu, HI 96814
All Access Ortho	Mililani	808-356-5699	95-1830 Meheula Parkway Suite C10 and 11 Mililani, HI 96789
American Current Care of Hawai‘i	Honolulu	808-831-3000	545 Ohohia Street Honolulu, HI 96819
Braun Urgent Care Kailua	Kailua	808-261-4411	130 Kailua Road, Suite 111 Kailua, HI 96734
Concentra Urgent Care	Honolulu	808-831-3000	545 Ohohia Street Honolulu, HI 96819
Ho‘ōla Health Urgent Care	Honolulu	808-208-8700	2055 N King Street Honolulu, HI 96819
Kunia Urgent Care	Waipahu	808-983-1671	94-673 Kupuohi Street, Suite C201 Waipahu, HI 96797
Minute Clinic (CVS Locations)	Aiea	808-488-0958	98-130 Pali Momi Street Aiea, HI 96701
Minute Clinic (CVS Locations)	Honolulu	808-947-2651	2470 South King Street Honolulu, HI 96826

Urgent Care center	City	Phone	Address
Minute Clinic (CVS Locations)	Kahala	808-732-0781	4211 Waialae Avenue Honolulu, HI 96816
The Island of O‘ahu (continued)			
Minute Clinic (CVS Locations)	Kailua	808-261-9794	609 Kailua Road Kailua, HI 96734
Minute Clinic (CVS Locations)	Kaneohe	808-235-5805	480 Kaneohe Bay Drive 45 Kaneohe, HI 96744
Minute Clinic (CVS Locations)	Kapolei	808-674-0269	590 Farrington Highway Kapolei, HI 96707
Minute Clinic (CVS Locations)	Wahiawa	808-621-7772	925 California Avenue Wahiawa, HI 96786
Minute Clinic (CVS Locations)	Waikiki	808-922-8790	2155 Kalakaua Avenue Honolulu, HI 96815
Queen’s Island Urgent Care	Hawaii Kai	808-735-0007	6600 Kalanianaole Highway Suite 114A Honolulu, HI 96825
Queen’s Island Urgent Care	Hawaii Kai	808-735-0007	377 Keahole Street Honolulu, HI 96825
Queen’s Island Urgent Care	Waialae	808-735-0007	4218 Waialae Avenue, Suite 106 Honolulu, HI 96816
Queen’s Island Urgent Care	Pearl Kai	808-735-0007	98-199 Kamehameha Highway, Building F Aiea, HI 96701
The Queen’s Island Urgent Care	Ewa/ Kapolei	808-735-0007	91-6390 Kapolei Parkway Ewa Beach, HI 96706
The Queen’s Island Urgent Care	Kahala	808-735-0007	1215 Hunakia Street Honolulu, HI 96816

Urgent Care center	City	Phone	Address
The Queen's Island Urgent Care	Kakaako	808-735-0007	400 Keawe Street, Suite 100 Honolulu, HI 96813
The Island of O'ahu (continued)			
The Queen's Island Urgent Care	Kapahulu	808-735-0007	449 Kapahulu Avenue Suite 104 Honolulu, HI 96815
Urgent Care Clinic of Waikiki	Waikiki	808-924-3399	2155 Kalakaua Avenue, Suite 308 Honolulu, HI 96815
Adventist Health Castle Urgent Care	Honolulu	808-921-2273 COVID-19 tests only	1860 Ala Moana Boulevard Suite 101 Honolulu, HI 96815
Adventist Health Castle Urgent Care	Kailua	808-263-2273	660 Kailua Road Kailua, HI 96734
Adventist Health Castle Urgent Care	Kapolei	808-521-2273	890 Kamokila Boulevard Kapolei, HI 96707
Adventist Health Castle Urgent Care	Pearl City	808-456-2273	1245 Kuala Street, Suite 103 Pearl City, HI 96782
Windward Urgent Care	Kaneohe	808-234-1094	45-1141 Kamehameha Highway Kaneohe, HI 96744

Other plan details

What is prior authorization?

You need permission, called "prior authorization," to get some services under QUEST Integration. Your provider works with us to get prior authorization. UnitedHealthcare Community Plan QUEST Integration will only cover services that have been authorized.

Your provider may bill you directly:

- For services not covered by the health plan
- For services that have not been authorized by the health plan
- For covered services where health plan rules were not followed
- For covered services that have exceeded benefit limits

Your provider must obtain written consent from you prior to rendering the services to confirm that you are accepting financial responsibility for any non-covered services or for covered services that have exceeded benefit limitation.

What services may require a prior authorization?

You do not need prior authorization for emergency services or to go to an urgent care clinic or facility. You do not need it to see a women's health provider that is not in our provider network for emergent women's health or if you are pregnant and in your second or third trimester the day before you are enrolled with UnitedHealthcare Community Plan.

Prior authorization is needed for:

1. Non-emergent inpatient stays for medical and behavioral health services.
2. Some ambulatory surgery in a hospital or surgery center.
3. Nursing facility or other long-term care facility stay.
4. Out-of-network and out-of-state non-emergent services.
5. Off-island referral (travel to another island for covered services).
6. Hospice services (prior authorization is required only for services provided in an inpatient hospital).
7. Home health services, including infusion therapy.

8. Medical equipment, prosthetics and orthotics over $500 per item (purchase price or monthly rental).
9. Medical supplies provided outside of a health care facility.
10. Incontinent supplies provided outside of a health care facility.
11. Genetic testing.
12. Organ transplants (will refer member to the State of Hawai'i SHOTT program).
13. Abortion or Intentional Termination of pregnancy (will refer member to the State of Hawai'i's fiscal agent).
14. Pain management services.
15. Sleep studies/Sleep therapy.
16. Transportation (non-emergent) — ground and air.
17. Substance abuse residential treatment facilities.
18. Psychological testing.
19. Substance abuse observation.
20. Detoxification services.
21. Methadone maintenance.
22. Specialty drugs (see formulary).
23. Covered dental services.
24. Experimental and investigational.
25. Applied Behavioral Health (ABA) for Autism Spectrum Disorder (ASD) or other therapies.
26. Gender Dysphoria services (i.e., Gender affirmation, gender change, sex change, sex reassignment, sex reversal, sex transformation surgery, transsexual surgery, or transgender surgery). Talk to your doctor if you think you need these services.
27. Medications not on our Preferred Drug List.
28. Long-term services and supports.
29. Home and Community Based Services.
30. Community Integration Services (CIS).
31. Going Home Plus (GHP) and institutional relocation services.

Your primary care provider (PCP) and Member Services know what services need prior authorization. The list may change. For a current list, contact Member Services toll-free at **1-888-980-8728** (TTY users **711**).

How long does it take to review a prior authorization request for a decision?

We will notify you and your provider in writing of all prior authorization decisions as follows:

- Within fourteen (14) calendar days of the receipt of a request for routine or standard prior authorization requests
- Within seventy-two (72) hours of the receipt of a request for urgent prior authorization requests

An extension may be granted for up to fourteen (14) additional calendar days if you or your provider requests an extension, or if we justify a need for additional information and the extension is in your best interest. We will notify you and your provider in writing of the reason for the extension and your rights to file a grievance if you disagree with our decision.

Call Member Services if you have questions about prior authorization.

Authorizations are subject to medical necessity review. If your request for a service is denied or limited, you can ask for an appeal. If you have questions about prior authorizations or want to ask for an appeal, call Member Services toll-free at **1-888-980-8728** (TTY users **711**). Staff can answer your questions. Language translation can be arranged. You can also write us if you need information about authorization or prior authorization at:

UnitedHealthcare Community Plan
1132 Bishop St., Suite 400
Honolulu, HI 96813

A licensed clinical professional reviews all cases or prior authorization requests in which the care does not appear to meet guidelines. Decisions on coverage are based on the appropriateness of care and the coverage. They are not influenced by financial incentives. Members and providers can appeal a denial. Information on appeals will be provided in the denial letter.

The appeal must be submitted within 60 calendar days of the denial letter, also called a Notice of Adverse Benefit Determination.

Utilization Management (UM) decisions

The services you get are very important to us. We help you get the right care, at the right time, in the right setting. We don't want you to get too little care or care you don't need. Professionals such as doctors and pharmacists decide what services are covered. These decisions are based on medical necessity. We do not reward our UM team for decisions they make about a member's care.

Medically necessary covered services shall be provided in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services provided to individuals under the Medicaid Fee For Service program. UnitedHealthcare Community Plan will not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of the diagnosis, type of illness, or condition.

UnitedHealthcare Community Plan provides all covered services required in our contract with the Department of Human Services (DHS).

How to contact our Utilization Management (UM) team

Our UM team is available from 7:45 a.m.–4:30 p.m. HST, Monday–Friday, to help you with utilization management or prior notification questions. You can reach the team by calling toll-free: **1-888-980-8728** (TTY users **711**). Language translation is available for members. After-hours assistance is available for providers through Physicians Exchange.

Transportation

How do I get to the doctor's office?

Medical transport is covered for health care treatment or evaluation in some cases. If you have no way to get to the doctor, you live in an area with no public transport or you cannot use public transport because of your medical condition, call ModivCare. ModivCare is our QUEST Integration Transportation Services vendor. The toll-free number is 1-866-475-5746 (TTY 1-866-288-3133). If you, your relatives, friends, volunteers or the facility you live in can provide the transport, you should not use the QUEST Integration transportation benefit.

We will help decide the right transportation for you based on your medical need. We pay for the least costly transport, based on availability and member need.

Call ModivCare for a ride as soon as you make your doctor's appointment or at least 48 hours in advance prior to your doctor's appointment date. A doctor's appointment must be scheduled prior to calling ModivCare to schedule a ride. Member Services can help you set up transportation services for appointments on another island or out-of-state. All doctor appointments should be scheduled for Monday through Thursday and no later than 2:00 p.m. Transportation requests for a Monday appointment should be made by Thursday noon. Any request for special equipment such as child safety booster seats, must be made when scheduling your transportation with ModivCare.

To learn more, sign in to **myuhc.com/CommunityPlan** and select "Coverage & Benefits" to search for transportation coverage.

What if I cannot take the bus?

If you are eligible for services through **TheBus**, ModivCare will give you bus passes. If you live in an area not served by the bus or you cannot take the bus due to disability, we have other options. Handi-Van service is available on O'ahu. Every island has different para-transit providers. ModivCare can help you set up an appointment or contact the right agency to see if you qualify for Handi-Van service or you may call the Handi-Van Eligibility Center at 538-0033 for information or to schedule a face-to-face interview.

The Handi-Van Eligibility office is located at:

The First Insurance Center
1100 Ward Ave. Suite 835
Honolulu, HI 96814-1613

If these options are not available, we will look for other ways to meet your needs.

How do I get trip coupons for Handi-Van services?

If you are eligible for Handi-Van service, QUEST Integration Transportation Services ModivCare will give you coupons.

If you need a Handi-Van coupon, call ModivCare five (5) calendar days in advance so the coupons can be mailed.

If you have recurring trips, ModivCare will mail you public para-transit trip coupons for the entire month. If you do not use up all your trip coupons by the end of the current month, the number of trip coupons for the following month will be reduced by 5. For example, if you received 40 trip coupons for the current month and only used up 20 trip coupons, you will be sent 19 trip coupons for the following month (this is based on trip coupons used rounded to the nearest 5).

If you need more bus passes or trip coupons, call ModivCare. They may authorize more passes or other types of transport.

What if I have special medical needs and cannot use Handi-Van services?

The use of other private para-transit or transportation services may be available to members who cannot use public bus or Handi-Van services due to medical needs.

Your PCP must certify your medical transportation needs to use any private para-transit or transportation services. Your PCP must complete the Certification of Medical Necessity of Mode of Transportation Medicaid-covered Services to determine the best means of transportation for you. The services could be:

- Door-to-door service
- Wheelchair level of service
- Non-emergency stretcher service (gurney)
- Escort required

If approved, taxis will be used only if no other transport is available.

How do I make an appointment for ground transportation services?

All non-urgent transportation services must be set up **48 hours in advance, prior to your doctor's appointment**. Call ModivCare toll-free at 1-866-475-5746 (TTY users 1-866-288-3133), Monday–Friday. Requests for a Monday trip should be made by Thursday noon.

Call for a ride as soon as you make your doctor's appointment or at least 48 hours in advance, prior to your doctor's appointment. A doctor's appointment must be scheduled prior to calling ModivCare to schedule a ride. ModivCare can help you make ground transportation arrangements for medical appointments.

Reservations may be made by you, your representative, or your provider. You need to tell ModivCare your QUEST Integration member ID number, the pick-up and destination address. The customer service representative (CSR) will check that you are eligible. You are eligible if you are enrolled in our QUEST Integration program, can't transport yourself and the trip is approved by UnitedHealthcare based on confirmed scheduled appointment with your provider(s).

Some services need prior authorization. Ask Member Services or your provider to get authorization if needed. Prior authorization is needed for all off-island transportation (i.e., travel to another island or to the Mainland). If you decide to pay for your off-island transportation on your own without getting a prior authorization first from us, then you cannot submit a request for reimbursement. Refer to **page 137** of this Member Handbook for prior authorization rules.

If a non-urgent transport is requested with less than 48 hours' notice, you will be reminded about the advance notice policy. The trip will be scheduled and a note will be made in your record. On the third request for transport with less than 48 hours' notice, you will be asked to change the appointment.

The CSR will give you a pick-up time and an ID or reference number for the trip. You must be ready 15 minutes before the pick-up time. Save the trip number to help the CSR if there is a change or a complaint.

If you do not have a return ride scheduled, call **"Where's My Ride?"** toll-free at 1-866-475-5748 when your doctor's appointment is finished. ModivCare will have someone come and take you home. Please note that traffic and/or other unforeseen circumstances may cause a delay for pickup.

What if my ride is late?

If your ride is more than 15 minutes late, call "Where's My Ride?" The number is toll-free: 1-866-475-5748. You can download for free the ModivCare Trip Manager application (app) to check the status of your ride directly from your mobile cell phone or device. If you need help in setting up a free account, call ModivCare at the telephone number listed above.

How do I get rides for trips I need on a regular basis?

Your PCP or provider must ask for recurring appointments. The request must be made once per quarter. The provider may call ModivCare toll-free at 1-866-475-5746 (or fax 1-866-475-5745).

How do I make a request for transportation to an urgent care appointment?

Requests for urgent transport may be made with less than 48 hours' notice. "Urgent" is a medical problem that needs care within twenty-four (24) hours, but is not an imminent threat to life or health. We will confirm that you have an urgent care appointment or are seeing an urgent care provider. For urgent transport on the weekend, call 1-866-475-5746 (TTY users 1-866-288-3133).

What if there is an emergency?

If your health may be in jeopardy, call **911**. UnitedHealthcare Community Plan QUEST Integration covers the ambulance for an emergency. No prior authorization is needed.

What is Ride-Share?

We have the right to set up transport for multiple members, if the trip does not take 30 minutes longer than if you had gone by yourself. This is called "Ride-Share."

Can someone ride with me to my appointment?

If you need someone to help you during the transport or at your doctor's appointment, you may be able to bring an escort, if you have prior approval from UnitedHealthcare. This is usually a relative, guardian, or volunteer. We can also find you an escort within our provider network if you need one. An escort is an adult that can assist or help you during the travel. For example, you may need someone that can help you with pushing your wheelchair, help you with getting up or down from a chair or bed, and/or help guide you from one place to another if you are having trouble with your vision or eyesight. If approved, only one escort per member is **normally** covered. You must prove a need for an escort. Transport for an escort to your medical appointments needs prior authorization from us.

An escort is allowed for members under the age of 18. A member age 18 or older must have medical certification from your PCP before we will authorize one. A child or infant may ride with their single parent to their parent's doctor's appointment due to lack of childcare.

What if I have to travel to another island for my medical care?

All non-emergency transport or travel to another island needs prior authorization. Travel must be set up by ModivCare. Travel is based on your scheduled doctor's appointment. To set up travel to another island, your doctor must request at least fourteen (14) calendar days in advance, whenever possible. ModivCare will provide you with a copy of your itinerary. UnitedHealthcare will not reimburse or pay for off-island travel set up by you directly or without a prior authorization from us.

If you need someone to help or escort you during the travel and to your scheduled medical appointments, your doctor must ask us for prior authorization so that we can determine if it is medically necessary to have an escort. The escort is usually a relative, guardian, or volunteer. We can also find you an escort within our provider network if you need one. An escort is an adult that can assist or help you during the travel. For example, you may need someone that can help you with pushing your wheelchair, help you with getting up or down from a chair or bed, and/or help guide you from one place to another if you are having trouble with your vision or eyesight.

If the adult member is required to be hospitalized and it is not necessary for the approved escort to remain with the member, we will arrange for the approved escort to return to his or her home island. If it is medically necessary for an escort to accompany the member home on the day of discharge, we will arrange for the approved escort's travel.

What if I have to travel out-of-state for my medical care?

All non-emergency travel out-of-state or to the Mainland needs prior authorization. Travel must be set up by ModivCare. ModivCare will provide you with a copy of your itinerary. When out-of-state travel is authorized, lodging and ground transport will be provided for you. UnitedHealthcare will not reimburse or pay for travel set up by you directly or without a prior authorization from us.

Meals and lodging for travel to another island or out-of-state

Lodging and meal vouchers are given for you and any approved escort. If you decide to pay out-of-pocket for meals for the approved travel and then ask for reimbursement later, you can send your request for reimbursement to ModivCare along with a copy of your itemized receipt(s) for verification.

Meal reimbursement for medical services authorized for one day travel to another island:

- Reimbursement will not exceed $15 per day for the member and $15 per day for approved escort

Meal reimbursement for medical services authorized for more than one day for travel to another island or out-of-state:

- Reimbursement will not exceed $30.00 a day for members age 11 and older (including authorized escort) and $15.00 a day for members age 10 and younger
- Reimbursement is allowed for members under the age of 3 that can eat orally but not to exceed $15 a day
- Reimbursement is allowed for one round trip travel to a restaurant or eating establishment if there is none available within a half-mile (1/2) from your hotel/motel. The date of the travel receipt to the restaurant or eating establishment must match the date and time frame of the receipt from the restaurant or eating establishment.
- Reimbursement is allowed if you use your EBT card or Supplemental Nutrition Assistance Program (SNAP) benefits to purchase food
- Reimbursement is not allowed for the member for the days the member is in a hospital (time starts when the member is admitted into the hospital and ends when the member is discharged)
- Reimbursement is not allowed for tips and/or gratuity of any kind (including rides in a taxi, etc.)
- Reimbursement is not allowed for meal delivery fees when ordering food from a restaurant or eating establishment

Airline fees: Personal baggage or luggage fees for the airlines are not a covered benefit. UnitedHealthcare will not reimburse you for these fees.

What if I change health plans while I am away on another island or out-of-state for approved travel and covered services?

UnitedHealthcare will pay for your travel back to your home island and will assist with transition of care to your new health plan.

What kind of transportation is not covered by UnitedHealthcare Community Plan QUEST Integration program?

- Transport services when a prior authorization is required but not obtained
- Transport related to services that are not medically necessary
- Transport to a pharmacy
- Transport for personal errands such as shopping or visiting
- Transport to a SSI Determination Medical Appointment or Medicaid eligibility
- Transport to classes, support groups, community events, etc., unless included as part of the health action plan
- Transport for any services not covered under the QUEST Integration program
- Rental cars on island of residence, during an off island and/or out of the state travel regardless if the travel was approved by us
- Transportation by ambulance from hospital to hospital for non-emergent services (facility is responsible for these services)
- Transportation for individuals that have Medicare or other insurance coverage that is primary to Medicaid. Medicare or other primary insurance and Medicaid have different benefits and coverage policies. Under your primary insurance coverage, you may be able to seek health care services on a different island from the one you live on. However, Medicaid requires that you receive care on the island where you live if those services are available on the same island. If you travel to another island or to the mainland and those health care services are available on your island of residence, we will not pay for your transportation.

Pharmacy

Does UnitedHealthcare Community Plan QUEST Integration provide prescription drugs?

We provide prescription drugs and other pharmacy services. QUEST Integration members do not have copayments for their pharmacy benefits.

If you have Medicare, your Medicare Part D plan will cover most of your drugs. You may have Part D copayment for your medications. UnitedHealthcare QUEST integration does not cover Medicare Part D copayments. There are certain drugs and over-the-counter medications not covered by Medicare Part D that UnitedHealthcare Community Plan QUEST Integration may cover. Don't forget to bring your Medicare Part D and your QUEST Integration member ID cards to your doctor's appointments or to the pharmacy.

Your QUEST Integration plan covers many drugs. We use a formulary called a Preferred Drug List (PDL) for your coverage. A Preferred Drug List is a list of medicines that we will cover. Having a Preferred Drug List helps your doctor prescribe medicines or medication for you. If your drug is not on the list, we may ask your doctor to use a similar drug. If you pay for drugs not on the list, we will not pay you back. See the QUEST Integration Preferred Drug List (medication list) on our website, **myuhc.com/CommunityPlan**.

Drugs not listed on the PDL:

If the drug is not listed in the PDL, your doctor may ask us for prior approval for you to get it.

Drugs listed on the PDL but requires a prior authorization:

If the drug is listed on the PDL but the drug requires a prior authorization, your doctor may ask us for prior approval for you to get it.

Your doctor must send a request to OptumRx for review and approval. A decision will be made within 24 hours of receiving the request.

UnitedHealthcare can provide an emergency supply of medication — up to a seven (7) day supply — until UnitedHealthcare can make a medical necessity determination regarding a new drug.

To ensure that your doctor has the most current PDL, UnitedHealthcare notifies providers at least thirty (30) days in advance of any drugs that will be deleted or removed from the PDL.

You can also call Member Services toll-free at **1-888-980-8728** (TTY users **711**) to find out about the drugs on the formulary or if want a copy of the formulary or PDL. You may have a Medicare Part D copayment for your medications. UnitedHealthcare Community Plan QUEST Integration does not cover Medicare Part D copayments. There are some medications that are not covered by Medicare Part D. It may be covered under your QUEST Integration pharmacy benefits at no charge.

Mail order services

UnitedHealthcare Community Plan QUEST Integration members can receive up to a 30 day supply of covered medications through our mail order program. Call Member Services toll-free at **1-888-980-8728** (TTY users **711**) to get started.

Members with UnitedHealthcare Medicare Dual Special Needs Program coverage can also receive their medication through mail order service. If you need help getting your drugs or are interested in the mail order program for home delivery, call Member Services toll-free at **1-888-980-8728** (TTY users **711**).

Retail pharmacies

Our UnitedHealthcare Community QUEST Integration members can go to participating pharmacies and get up to a 90 day supply of most covered medicines.

Our UnitedHealthcare Medicare Dual Special Needs Program can receive up to a 100 day supply of most covered medications at participating retail pharmacies.

How does the plan decide on new drugs, treatment or technology?

Your QUEST Integration plan covers many drugs. We use a formulary also called a Preferred Drug List for your coverage. A formulary is a list of medicines that a health plan will cover. Having a formulary helps your doctor prescribe medicines for you. New drugs and forms of treatment are being introduced every quarter after review by a committee. UnitedHealthcare Community Plan adds drugs to its formulary as needed.

A committee of doctors reviews new technology. They make recommendations on coverage.

Pharmacy High Prescription Utilization Program

Some members may need to be placed in a Pharmacy High Prescription Utilization Program. This program will help your pharmacist keep track of all medications that you may be taking in order to:

- Protect your health and keep you safe,
- Provide continuity of care,
- Avoid duplication of services by other providers,
- Avoid inappropriate or unnecessary utilization of your Medicaid benefits, and
- Avoid excessive utilization of prescription medications.

This program requires that you get all of your prescriptions from one pharmacy. This program doesn't change your current health care benefits and doesn't apply to specialty drugs.

How do I know if I am in this program?

We will send you a letter thirty (30) days before the effective or start date of the program.
The letter will:

- Explain the Pharmacy High Prescription Utilization Program
- Give you the opportunity to choose a pharmacy to fill your prescription

What do I have to do?

Please ask your doctors to send your prescriptions to the pharmacy that is listed in the letter that you received. It is important that you go to the pharmacy that is listed in the letter. If you go to another pharmacy, your prescription will be denied and you will be redirected to go to the correct pharmacy. We want to make sure that there is no delay in getting your medication.

Can I change my pharmacy?

If you go to another pharmacy, your prescription will not be filled and you will be redirected to go to your assigned pharmacy.

Questions?

If you have any questions or need help, please call Member Services toll-free at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m., Monday–Friday.

Medication Assisted Treatment Services

UnitedHealthcare has in place a Medication Assisted Treatment Services (MAT) policy to ensure that our Members have access to the full array of evidence-based and potentially life-saving treatment options, including MAT, that are determined to be medically necessary.

MAT is the use of medications, in combination with counseling and behavioral health therapies to provide a "whole-patient" approach to treatment of substance use disorders. MAT services range from pharmacological intervention, individual/group therapy, peer support services and crisis intervention.

UnitedHealthcare covers all drugs and biological agents approved or licensed by the FDA used for MAT to treat opioid use disorder.

Prior authorization requirements may vary depending on the type of service provided and for out-of-network providers.

If you have any questions or need help with MAT services, please call Member Services toll-free at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m., Monday–Friday.

Payment for services

Unless you have cost-sharing responsibility (refer to page 39 for an explanation on Cost Sharing), you do not have to pay for covered services as long as applicable health plan rules were followed. UnitedHealthcare will not pay or reimburse for services that are not covered by the health plan or for covered services where health plan rules were not followed. Your provider may bill you directly for services not covered by the health plan or for covered services where health plan rules were not followed. Your provider may also bill you directly for covered services that have exceeded benefit limits. Your provider or doctor must obtain written consent from you prior to rendering the services to confirm that you are accepting financial responsibility for any non-covered services or for covered services that have exceeded benefit limitation. If your provider or doctor did not obtain a written consent from you prior to rendering services that we do not cover or covered services that have exceeded benefit limits, your doctor or provider cannot hold you liable or balance bill you for those services.

All services should be provided by a UnitedHealthcare QUEST Integration participating provider unless no participating providers are available on your island of residency to provide timely medically necessary services. We do not require a prior authorization for emergency, urgently needed care and in the following situations:

1. Women who are in their second or third trimester of pregnancy the day before they are enrolled in UnitedHealthcare Community Plan QUEST Integration can continue receiving prenatal, delivery and postpartum services from their out-of-network OB/GYN or provider.
2. Members receiving medically necessary covered services the day before enrollment into the UnitedHealthcare Community Plan QUEST Integration plan can continue receiving services from their out-of-network provider:
   - At least ninety (90) calendar days or until the member has received a health and functional assessment by their Health Coordinator for individuals with Special Health Care Needs (SHCN) and those receiving Long-Term Services and Support (LTSS) services
   - At least forty-five (45) days or until the member's medical needs have been assessed or reassessed by the PCP who has authorized a course of treatment

Refer to page 137 of this Member Handbook for prior authorization requirements.

If you or your doctor need help finding a participating provider, please call Member Services at **1-888-980-8728** (TTY users **711**) for assistance.

Your doctor or provider must submit a claim to UnitedHealthcare QUEST Integration for payment and we will pay your doctor or provider directly.

To avoid paying for services out of your own pocket, you should ask your doctor or provider the following questions to make sure that the recommended service(s) will be covered by your health plan, and that applicable health plan rules are followed:

1. Is the service(s) you are recommending covered by my health plan?
   a. If the service(s) is not covered by my health plan, are there other options that are covered by my health plan?
   b. If there are no other options that are covered by my health plan:
      i. Can you refer me to another doctor or provider for a second opinion?
         1. If both doctors agree that there are no other options that are covered by your health plan, but they feel that the recommended services are medically necessary, then ask your doctor if they will submit a prior authorization request to UnitedHealthcare.
2. Does the service(s) you are recommending need a prior authorization from my health plan?
   a. If so, will you be submitting a prior authorization to my health plan?
   b. How will I know if my health plan approved the prior authorization request?
   c. If my health plan denies the prior authorization request, can you walk me through next steps?
3. Does the doctor or provider you are referring me to for service(s) participate with my health plan?
   a. If not, can you refer me to a provider that participates with my health plan?
   b. If there are no available participating providers, can the services be provided by a non-participating provider and if so, will you submit a prior authorization request to my health plan?
   c. How will I know if my health plan approved the prior authorization request?
   d. If my health plan denies the prior authorization request, can you walk me through next steps?
4. If your doctor or provider refers you to an urgent care center that does not participate with UnitedHealthcare Community Plan for non-emergent services such as an X-ray for reasons that they do not have an X-ray machine or equipment, you should ask your doctor or provider the following questions:
   a. Can you refer me to a participating provider?
   b. If there is no available participating provider, will you submit a prior authorization request to my health plan?
   c. How will I know if my health plan approved the prior authorization request?
   d. If my health plan denies the prior authorization request, can you walk me through next steps?

What if I pay out-of-pocket for covered services?

You should not pay out of your own pocket for services that are covered by UnitedHealthcare Community Plan QUEST Integration program. We will not reimburse you if you pay out-of-pocket without getting a prior approval from UnitedHealthcare.

Covered services must be provided by a UnitedHealthcare Community Plan QUEST Integration participating provider unless there are no available participating providers that can provide medically necessary service(s) within the time frame that is necessary to treat your medical condition. Your doctor or provider must submit a claim to UnitedHealthcare Community Plan QUEST Integration program for payment. Payment will be made directly to your doctor or provider. The payment amount will be based on the participating provider's contract with UnitedHealthcare Community Plan.

We will reimburse non-participating providers for covered services, as long as all applicable health plan rules are followed. We will not reimburse you if you pay out-of-pocket without getting a prior approval from us.

Member reimbursement requests

Call Member Services to discuss your request. Remember, we will not reimburse you if you pay out-of-pocket without getting a prior approval from us. Member Services can provide you with a reimbursement form that must be completed and returned to UnitedHealthcare Community Plan. Reimbursement request forms must include all required information, and must be received by UnitedHealthcare Community Plan within one year from the date of when the service(s) was provided. Required documentation includes copies of receipts, itemized bill, explanation of benefits (EOB) from your primary carrier and any other additional information that we may need in order to make a decision. We will reimburse only for requests that have been prior authorized by us.

We will review all member reimbursement requests to determine if all of the following health plan rules were met:

1. Was the service(s) provided a covered benefit?
2. Does the covered service(s) require a prior authorization, if so, is there a prior authorization on file?
3. If the covered service(s) was provided by a non-participating provider, is there a prior authorization on file?

How much will I get reimbursed for covered services?

Reimbursement amount will be based on the UnitedHealthcare Community Plan QUEST Integration Medicaid Fee Schedule and will be determined once your request has been processed. We will **only** reimburse up to the UnitedHealthcare Community Plan QUEST Integration Medicaid Fee Schedule allowed amount **or less**. If the amount you paid your doctor or provider is less than the UnitedHealthcare Community Plan QUEST Integration Medicaid Fee Schedule allowed amount, we will reimburse you only the amount you paid. **This is why it is very important that you do not pay for covered services out of your own pocket.** We will notify you of the reimbursement amount once your request has been processed in our system.

What if I get a bill from my doctor or other provider?

If you get a bill from a doctor, hospital, or other provider, ask them why they are billing you. Give them your UnitedHealthcare Community Plan QUEST Integration insurance coverage information and tell them to send us a claim. Please remember that UnitedHealthcare QUEST Integration will pay **only** for covered services, and health plan approved non-covered services as long as all applicable health plan rules were followed. Your doctor or provider cannot balance bill you for those services.

Who do I call if I get another bill from the same doctor or provider?

Call Member Services at **1-888-980-8728** (TTY users **711**). Be sure you have your bill in front of you. You need to tell Member Services who sent the bill, the date of service, the amount of the bill and the provider's address and phone number. You also need to give your name, UnitedHealthcare Community Plan QUEST Integration member ID number, and other information upon request. We will call your doctor or provider to discuss the bill to determine necessary action to help resolve the bill.

If I choose to get services that are not covered by UnitedHealthcare Community Plan QUEST Integration without a prior authorization, can my doctor bill me for these services?

Your doctor must have on file an Advanced Beneficiary Notification (ABN) or written documentation that you have agreed to pay for the non-covered services not authorized by us. The ABN must be signed by you and your doctor's office confirming that you have agreed to receive and pay for the non-covered services (this includes covered services that have exceeded benefit limitation) before the services are provided.

What if I have other health insurance in addition to QUEST Integration?

As a condition of QUEST Integration eligibility, you must report all insurance information to the DHS. If your private health insurance is canceled, if you have new insurance coverage, or if you have questions about third party insurance, call Member Services at **1-888-980-8728** (TTY users **711**). Having other insurance does not affect whether you qualify for QUEST Integration except if you have Medicaid from another state. You cannot have Medicaid coverage with multiple states. You have to make sure that your Medicaid insurance coverage with another state has been terminated to prevent claims denials.

UnitedHealthcare Community Plan will coordinate health care benefits with other insurance carriers or coverage such as commercial, Medicare, third party liability (such as an automobile or motor vehicle insurance carrier, private home insurance, etc.). QUEST Integration will always be the last payer of resort.

Rights and responsibilities

What are my health care rights and responsibilities as a member of the UnitedHealthcare Community Plan QUEST Integration program?

UnitedHealthcare Community Plan QUEST Integration has written policies and procedures to ensure compliance with federal and State laws and regulations pertaining to member rights. UnitedHealthcare Community Plan QUEST Integration ensures that its employees, contracted providers and sub-contractors and vendors observe and protect all member rights.

As a QUEST Integration member, you have the right to:

- Get information on your rights and in a way that you can understand easily, in alternative formats such as Braille or audio, and in a manner that takes into consideration any special needs you may have. Member information is available in Ilocano, Vietnamese, Chinese (Traditional) and Korean. These services are available at no cost to you.
- Be treated with respect for your dignity and privacy
- Have all records and medical and personal information kept private
- Get information on available treatment options, in an easy-to-understand way, regardless of cost or benefit coverage
- Take part in decisions on your health care, including the right to refuse treatment
- Be free from any form of restraints or seclusion unless it is needed for your health or for safety. Treatment shall not be used to control, punish, retaliate nor to be used for convenience only.
- Ask for and get a copy of your records and ask to amend or correct them
- Get health services in accordance with 42 CFR Sections 438.206 through 438.210 (e.g., availability of services, or get information in a way that you can easily understand)
- Freely use your rights and file a complaint or appeal without any effect on the way you are treated
- Have direct access to women's health care services and women's health providers that participate with UnitedHealthcare Community Plan QUEST Integration
- Get a second opinion from an in-network provider at no cost

- Get services from non-UnitedHealthcare Community Plan QUEST Integration providers, without having to pay extra, if the type of service you need is not available in our network
- Get services per waiting time standards. The waiting time standards for appointments is listed on page 44 under the section **How long should it take to get a PCP or doctor's appointment**.
- Get care in a way that works for your culture
- Get coordinated services
- Have your privacy protected
- Take part in your service and care plan development, if you need one
- Have direct access to special doctors (if you have a special health care need)
- Not have services arbitrarily denied or reduced in amount, duration or scope solely due to diagnosis, type of illness or condition
- Get facts on cost sharing, if any. See page 39 under section **What is Cost Share (Enrollment Fee)** for additional information on cost sharing.
- Get information about UnitedHealthcare Community Plan, its services, its organization, providers and practitioners
- Get a copy of these rights and responsibilities and make recommendations to them. Have them explained to you if you have questions.
- Only be responsible for cost sharing that is allowed by the DHS
- Patients' Bill of Rights and Responsibilities under Hawai'i Revised Statutes (HRS) 432E. These rights include but are not limited to information about medical necessity, utilization reviews, grievance and appeals (including expedited internal appeal), request for external review (including expedited reviews), taking part in decision makings related to your health care, etc. Additional information about these rights can be found throughout the Member Handbook.
- **Not** be held liable for:
  - UnitedHealthcare Community Plan's debts if UnitedHealthcare Community Plan goes out of business
  - The covered services provided by UnitedHealthcare Community Plan for which the DHS does not pay UnitedHealthcare Community Plan
  - Covered services for which DHS or UnitedHealthcare Community Plan does not pay the provider
  - Payment of covered services given under a contract, referral, or other arrangement that is more than what you would owe if UnitedHealthcare Community Plan provided the services directly

Other plan details

We will notify you in writing of a major change or any change in program information, including network provider termination. We will notify you at least thirty (30) days prior to the intended effective date of the change and/or termination or fifteen (15) days after receipt or issuance of the termination notice.

As a QUEST Integration member and as a partner in your healthcare, you have the responsibility to:

- Understand each right you have under the QUEST Integration program
- Ask questions if you do not understand your rights
- You must report changes that may affect your membership to your DHS case worker within ten (10) days of the change. Examples of changes include change in household (movements in and out of a household, mailing address, phone number), death of a member or family member (spouse or dependent), transfer to LTSS, change in health status (pregnancy or permanent disability) or employment (part-time or full-time job, including loss of job). You must also report when someone is admitted into a state mental hospital, Hawaii Youth Correctional Facility, or prison, inability to meet citizenship, alien status, photo and identification documentation requirements, change in social security number, marriage, divorce, birth or adoption of a child, other health insurance coverage, etc.
- Follow the QUEST Integration and Medicaid policies and procedures
  - Learn and follow UnitedHealthcare Community Plan and Medicaid rules
  - Choose a primary care provider
  - Make changes in your primary care provider as set up by UnitedHealthcare Community Plan
  - Keep your appointments
  - Cancel appointments in advance and in a timely manner (i.e., at least 48 hours prior to your scheduled appointment date)
  - Contact your primary care provider first for non-emergency care
  - Get approval from your primary care provider before going to a specialist
  - Understand when you should go to the emergency room
- Share health information that UnitedHealthcare Community Plan, your doctor or other health provider needs to provide care
  - Talk to your providers about your health. Ask questions about your care.
  - Help your providers get your medical records

- Take part in decisions about treatment, make choices, and take action to maintain your health
  - Work with your provider to decide what care is best
  - Understand your health problems and how things you do affect your health
  - Be informed about treatment options
  - Follow the advice, health action plans, and instructions you agreed to with your doctor. Let your doctor know if you need to make a change.
  - Treat providers and their staff with respect
- Report any wrongdoing or fraud you think may be happening
- Take appropriate care of medical equipment and supplies provided to you
- Other Member responsibilities are listed throughout this document (i.e., request a replacement member ID card, report suspected fraud or abuse, etc.)

Grievances and appeals

We can help you when you have questions or a grievance about your QUEST Integration services. You may not always be happy with our responses to your questions. You can express your dissatisfaction by filing a grievance or appeal. Our Member Services staff in Hawai‘i is here to help you with this.

You may want your doctor or someone else to represent you. You can tell us who it is. Be prepared to give your written consent. You can use your own paper to tell us who you would like to represent you or you can use our Appointment of Representative (AOR) Form. You can download a free copy of the AOR Form by visiting **myuhc.com/CommunityPlan**. You can also call Member Services toll-free at **1-888-980-8728** (TTY users **711**) to request a free copy to be sent to you by mail, fax or email. This will help us know that we are assisting the right person.

Your first language may not be English. We can give the information in your preferred language. We can do this through written translation or oral interpretation. Call to access a telecommunication device for the deaf or text telephone TTY users **711** if you are hearing impaired.

Your grievance or appeal will be reviewed by someone who has not been involved in deciding anything about your case at any level. A health care professional with the appropriate clinical expertise will review cases that deal with clinical services such as:

- A grievance or appeal that deals with clinical issues
- A grievance that deals with a review of an expedited appeal
- An appeal that approves a service that is less than the service requested
- An appeal of a denial due to lack of medical necessity

Grievances

What is a grievance?

A grievance is when you are not happy with us or one of our providers. Examples of something that you might not be happy about are:

- Issues with quality of service or care
- How the Plan or your provider runs their office
- If the Plan or your provider was rude
- Wait times during provider visits
- Not getting the information you need
- Failure to respect your rights even if corrective action is requested against the Plan
- You disagree with the time proposed by the Plan to make decisions for prior authorizations

A grievance does not include being unhappy with an adverse benefit determination that was made by the Plan.

What should I do if I have a grievance?

We want to help. You, your representative, or provider with your written consent on your behalf can let us know by calling or writing to us. If you need, an interpreter can be provided at no cost. You can email us your grievance at **hi_ag@uhc.com**. You can call us toll-free at **1-888-980-8728** (TTY users **711**). You can also send it in writing to:

UnitedHealthcare Community Plan
Attention: Appeals Department
1132 Bishop St., Suite 400
Honolulu, HI 96813

Fax: 1-844-700-7938

What are the time limits for filing a grievance?

There is no time limit on filing a grievance with us.

What happens after you get my grievance?

After we get your grievance, we will send you a letter within 5 business days. This letter will tell you that we got your grievance. We will also let you know about the results of your grievance in writing. This letter will be sent to you within 30 calendar days after we get your grievance.

What if I am not happy with your response to my grievance?

If you are not happy with our response, you can request a grievance review from the DHS by calling the Med-QUEST Division at **1-808-692-8094**. You can also send it in writing to:

Med-QUEST Division Health Care Services Branch
P.O. Box 700190
Kapolei, HI 96709-0190

You must call or write to Med-QUEST within 30 calendar days from the date of our response.

Appeals

What is an appeal?

An appeal is when you are unhappy or do not agree with our decision or adverse benefit determination about health care related services. For example, an appeal can be filed when a covered service is denied, delayed, limited, or stopped. You can also file an appeal if a request for reimbursement is denied.

How do I file an appeal?

You, your authorized representative, or provider with your written consent on your behalf can let us know by calling or writing to us. If you need, an interpreter can be provided at no cost. You can email us your appeal at **hi_ag@uhc.com**. You can call us toll-free at: **1-888-980-8728** (TTY users **711**). You can also send it in writing to:

UnitedHealthcare Community Plan
Attention: Appeals Department
1132 Bishop St., Suite 400
Honolulu, HI 96813

Fax: 1-844-700-7938

You can give us evidence to support your appeal in person or in writing. We will let you know how to get the additional information to us. You or your authorized representative can review your case file, including medical records and any other document and records used before or during the appeals process.

What are the time limits for filing an appeal?

You must appeal within 60 calendar days of the date on the denial letter, also called a Notice of Adverse Benefit Determination.

What happens after you get my appeal?

After we get your appeal, we will send you a letter within 5 business days. This letter will tell you that we got your appeal. We will also let you know about the decision for your appeal in writing. This letter will be sent to you within 30 calendar days after we get your appeal. If you ask for more time, we may extend the time frame for up to 14 calendar days. If we need more information, we may also extend the time frame for up to 14 calendar days. We will call and send you a letter within 2 calendar days if we extend the time frame.

What happens with my service during the appeal process?

To continue to get service during an appeal, your request for an appeal must be received by us within 10 calendar days of the Notice of Adverse Benefit Determination or the date the service will be stopped, reduced or suspended. Services will only continue under the following conditions:

- You request an extension of benefits
- The appeal or request for State Administrative Hearing was filed in a timely manner
- The appeal or request for State Administrative Hearing involves the denial, reduction or suspension of previously authorized services
- The services were ordered by an authorized provider
- The original authorization period has not ended

If you do not ask for the appeal or hearing within 10 calendar days, your service may be stopped. If your appeal is denied, you may have to pay the cost of the service you received during the appeal.

What is an expedited appeal?

An expedited appeal is when you, your authorized representative, or your provider thinks that we need to make a quick decision based on your health. This is when taking the time for a standard appeal could risk your life, physical or mental health, or ability to attain, maintain, or regain maximum function.

How long will it take to process my expedited appeal?

We will notify you of our decision within 72 hours. We will also let you know about the decision for your appeal in writing. We will send a letter to your doctor. If you ask for more time, we may extend the time frame for up to 14 calendar days. If we need more information, we may also extend the time frame for up to 14 days. We will send you a letter if we extend the time frame.

What happens if we deny the request for an expedited appeal?

If we deny an expedited appeal, the appeal is then processed through the normal appeal process which will be resolved within 30 calendar days from the day we receive your appeal. We will call you to let you know that the appeal is not going to be processed as an expedited appeal, and we will also let you know that you can file a grievance. We will also send you a notice within two (2) calendar days. The notice will tell you that you may file a grievance with us for the denial of the expedited process.

What if I am not happy with your response to my appeal?

If you do not agree with our decision, you, your authorized representative, or your provider with written consent may ask for a State Administrative Hearing. You have 120 calendar days from the date on our adverse appeal decision letter to ask for a hearing. This process includes any appeal rights that the State may choose to make available to providers to challenge the failure of the Health Plan to cover a service. You can request a hearing by writing to:

State of Hawai'i
Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809

You have the right to have someone represent you at the hearing, such as a provider, or any authorized representative.

What is the Hawai'i Ombudsman Program?

The State of Hawai'i, Department of Human Services (DHS) oversees the Medicaid Ombudsman Program. Koan Risk Solutions is contracted with DHS to independently review concerns and complaints against Medicaid Health Plans as another resource for members. You can call the Medicaid Ombudsman on your island or visit their website at **http://www.koanrisksolutions.com**.

Hours of operations: 7:45 a.m.–4:30 p.m., Monday–Friday HST

Office address: Koan Risk Solutions, Inc.
1580 Makaloa Street #550
Honolulu, HI 96814

Koan contact information:

Oahu **808-746-3324**
Neighbor Islands. **1-888-488-7988**
TTY **711**
Email address. . . . . **hiombudsman@koanrisksolutions.com**

Advance Directives

UnitedHealthcare Community Plan covers advance care planning services between you and your provider without completing relevant legal forms. An example of relevant legal form(s) is a document that includes the name of the agent or individual that you may appoint to make decisions on your behalf. It also records your wishes pertaining to your medical treatment at a future time in the event that you are unable to make decisions regarding your care.

The patient's right to decide

All enrollees age 18 and older in health care facilities like hospitals, nursing homes, hospices, home health agencies, and health maintenance organizations have certain rights under Hawai'i law.

You have a right to file an "Advance Directive." An Advance Directive can be in the form of a Living Will or Durable Power of Attorney which allows you to state your choices about health care, or to name someone to make those choices for you, if and when you become unable to make those decisions about health care treatment for yourself. It also allows you to make decisions about your future health care treatment. This document says, in advance, what kind of treatment you want or do not want when you may be under special, serious medical conditions, conditions that could prevent you from telling your provider how you want to be treated. For example, if you were taken to a health care facility in a coma, you most likely would want the facility's staff to know your specific wishes about decisions affecting your treatment. An Advance Directive will let the providers know how you want your health care to be handled.

What is a Living Will?

A Living Will generally states the kind of health care you want or do not want if you become unable to make your own decisions. In Hawai'i, the definition of "Life Prolonging Procedures" was changed by the government to include giving food and water to a person with a terminal illness. It is called a "Living Will" because it takes effect while you are still living. Hawai'i's law provides a suggested form to use for a Living Will. You may use it or some other form. You may wish to speak to an attorney or provider to be certain you have completed a Living Will so that your wishes will be understood.

What is a Durable Power of Attorney?

A Durable Power of Attorney is a signed, dated and witnessed paper naming another person such as a husband, wife, daughter, son or close friend as your agent. This person will then be the one who will make health care decisions for you if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid. Hawai'i law provides a suggested form to use for a Power of Attorney. You may use it or some other form. You may wish to name a second person as a backup who will stand in, if your first choice is not available.

You may wish to have both a Living Will and a Power of Attorney, or you may want to combine them into a single document that describes treatment choices in a variety of situations and name someone to make health care decisions for you should you be unable to make these decisions for yourself.

Do I have to write an Advance Directive under Hawai‘i law?

No, there is no legal requirement to complete an Advance Directive. However, if you have not made an Advance Directive or designated a Health Care Surrogate, health care decisions may be made for you by a court-appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative, or a close friend in that order. This person would be called a “proxy.”

Can I change my mind after I write a Living Will or designate a Power of Attorney?

Yes, you may change or cancel these documents at any time. If you were temporarily unable to make decisions related to your health care and are now able to make your own decisions you can make changes to your Advance Directive. Make sure that someone like your provider, attorney, or family member knows of any change by providing them with a copy of the updated advanced directive. Any change should be written, signed and dated. You can also change an Advance Directive by oral statement.

What if I have filled out an Advance Directive in another state and need treatment in a health care facility in Hawai‘i?

An Advance Directive completed in another state, in compliance with the other state’s law, can be honored in Hawai‘i.

What should I do with my Advance Directive if I choose to have one?

Make sure that someone like your provider, attorney, or family member knows that you have an Advance Directive and where it is located. Consider the following:

- If you have a power of attorney, give a copy of the written designation form or the original to that person
- Give a copy of your Advance Directive to your provider for your health care file
- Keep a copy of your Advance Directive in a place where it can easily be found
- Keep a card or note in your purse or wallet that states that you have an Advance Directive and where it is located
- If you change your Advance Directive, make sure your provider, attorney and/or family member has the latest copy

Please note, you have a right to choose a new health care provider in situations when a health care provider cannot honor the Advance Directive wishes of his/her patients due to objections of conscience. If you believe your provider is not following Advance Directive laws and regulations, you may file a complaint by calling the Consumer Complaint Hotline toll-free at **1-800-324-8680**. You may also file a complaint with the DOH, Office of Health Care Assurance at 808-692-7227.

For further information, ask those in charge of your care or contact Member Services.

Hawai'i State law requires that any changes to Advance Directive laws be provided to you as soon as possible, but no later than ninety (90) days after the effective date of the change.

How can I make an Advance Directive?

You can speak with your primary care provider or an attorney or go to **myuhc.com/CommunityPlan** for additional information. Contact Member Services for a copy of the Five Wishes or the Hawai'i Provider Orders For Life-Sustaining Treatment (POLST) form for your use. You may also visit the Kokua Mau online website for information on advance care planning at **kokuamau.org/polst/**.

UnitedHealthcare Advance Directive Policy

You can find a copy of our Advance Directives Policy online at **myuhc.com/CommunityPlan**. A copy can also be mailed or sent in various electronic form (i.e., email, fax) to all members eighteen (18) years and older. If you would like a free copy, call Member Services toll-free at **1-888-980-8728** (TTY users **711**), 7:45 a.m.–4:30 p.m., Monday–Friday for assistance.

Confidentiality of member information

Privacy of member information and records is important to UnitedHealthcare Community Plan. There are several ways we protect your records.

- Members sign a release of medical records. This means you give us permission to get your health care records when researching a quality matter or health care inquiry.
- The Plan has written and implemented policies and procedures that protect the privacy of your data. This type of data can be released to a person or organization that has provided us your written consent.
- Contracts between the Plan and its health care providers include terms concerning the privacy of your records

UnitedHealthcare Community Plan is committed to maintaining the privacy of your records and data. If you have any questions regarding this information, please contact our Member Services department toll-free at **1-888-980-8728** (TTY users **711**).

Fraud, waste, and abuse

How do I report someone who is misusing the QUEST Integration program?

If you think a member or provider has committed fraud, waste, or abuse, you have a responsibility and a right to report it. Examples include a member sharing his or her QUEST Integration member ID card with someone else, a provider billing for services he or she did not perform, unnecessary services or supplies, or drugs given to others or resold.

To report fraud, waste or abuse, get as many facts as possible. You can write us at:

UnitedHealthcare Community Plan QUEST Integration
Attention: Compliance Department
1132 Bishop Street, Suite 400
Honolulu, HI 96813

Or you can call us toll-free at Member Services: **1-888-980-8728** (TTY users **711**).
Or our toll-free Fraud and Abuse Hotline at: **1-866-242-7727**.

When reporting a provider, list:

- Name, address and phone
- Name and address of facility (hospital, nursing home, home health agency, etc.)
- Type of provider (physician, physical therapist, pharmacist, etc.)
- Names and numbers of other witnesses
- Dates and summary of the fraud, waste or abuse events

When reporting a member, list:

- The person's name;
- The person's date of birth, if available;
- The city where the person lives; and
- Specific details about the waste, abuse or fraud.

Even if you do not know all of this information, you should still file a report.

Additional information available upon request

As a member of QUEST Integration you can get:

- UnitedHealthcare Community Plan practice guidelines
- Flyers related to the use of the Emergency Room, NurseLine, EPSDT and more. (See the end of this manual for sample flyers.)
- Annual member surveys (for example, timely access surveys, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, Hospitality Assessment and Retention Center (HARC) surveys)
- Procedures we use to control services and costs
- The number and outcomes of grievances and appeals filed by members
- Information on provider compensation incentive programs for performance
- Information on the health plan's leadership structure, and how we use our day-to-day operations to encourage providers to provide appropriate and quality services to UnitedHealthcare Community Plan QUEST Integration program members
- An updated provider directory, including names, addresses, phone numbers, and languages spoken (other than English) and a list of providers who are not taking new patients. This includes, at a minimum, primary care providers, specialists, and hospitals.

Call Member Services toll-free at **1-888-980-8728** (TTY users **711**) if you want any of this information.

All updates that we make to the Member Handbook must be approved by the DHS. This Member Handbook is available on our website at **myuhc.com/CommunityPlan**. We can also provide you with a paper copy of this Member Handbook within five (5) business days of the request at no cost. Let us know how many paper copies you need for your household by calling Member Services toll free at **1-888-980-8728** (TTY users **711**).

Quality programs

We want all members to be healthy and happy with the services we provide. That's why we have quality programs. Our quality programs work to give our members better care and services. We have a plan each year to list activities and goals to improve members' care and services. Activities include:

- Helping members with chronic illnesses get the care they need
- Working with pregnant women to have healthy babies
- Reminding members to get important tests and immunizations
- Making sure members get follow-up care after they are in the hospital
- Checking to see how certain illnesses are treated
- Checking to see if you are happy with the services we provide

Part of our process is measuring how well these programs are working. We check doctors' records. We look at claims data. We conduct member surveys to better help us understand the needs of our members and to get your feedback. We also conduct our member surveys periodically. Some surveys are required as part of our contract with the DHS to serve members. We listen to our members. We look at these results to see how we can do better. We share this information with providers and members through newsletters and in other ways. The results are used to develop and prioritize the next year's annual plan. Many of the things we measure on are major public health issues.

Reporting adverse events

If you or your caregiver would like to report an adverse event call Member Services toll-free at **1-888-980-8728** (TTY users **711**) for assistance. Examples of critical incidents include but are not limited to:

- Child/adult protective services reports or investigations involving participants or members, families, household members and service providers
- Involvement with criminal justice system
- Death
- Participant's whereabouts are unknown
- Falls while in the hospital, nursing facility, Community Care Family Foster Home, or in your own home
- Unexpected adverse outcome from a surgical procedure or hospital stay
- Substandard quality of care or service from a provider (i.e., care that is below what is considered standard, normal or acceptable)

Health Plan Notices of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2023

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

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

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

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

How we collect, use, and share your information

We collect, use, and share your HI with:

- You or your legal representative.
- Government agencies.

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

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

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

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

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

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

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

Your rights

You have the following rights.

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

- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website **(www.uhccommunityplan.com)**.
- **To ask that we correct or amend** your HI. Depending on where you live, you can also ask us to delete your HI. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

Using your rights

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-866-633-2446**, or TTY/RTT **711**.
- **To Submit a Written Request.** Mail to:
  UnitedHealthcare Privacy Office
  MN017-E300, P.O. Box 1459, Minneapolis MN 55440
- **Timing.** We will respond to your phone or written request within 30 days.
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

[1] This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus South Central Insurance Company; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus Wisconsin Insurance; Health Plan of Nevada, Inc.; Optimum Choice, Inc.; Oxford Health Plans (NJ), Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of River Valley; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; and UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

Financial Information Privacy Notice

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

Effective January 1, 2023

We[2] protect your "personal financial information" ("FI"). FI is non-health information. FI identifies you and is generally not public.

Information we collect

- We get FI from your applications or forms. This may be name, address, age and social security number.
- We get FI from your transactions with us or others. This may be premium payment data.

Sharing of FI

We will only share FI as permitted by law.

We may share your FI to run our business. We may share your FI with our Affiliates. We do not need your consent to do so.

- We may share your FI to process transactions.
- We may share your FI to maintain your account(s).
- We may share your FI to respond to court orders and legal investigations.
- We may share your FI with companies that prepare our marketing materials.

Confidentiality and security

We limit employee and service provider access to your FI. We have safeguards in place to protect your FI.

Questions about this notice

Please **call the toll-free member phone number on health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-866-633-2446**, or TTY/RTT **711**.

[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc. Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; Life Print Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; Optum Health Care Solutions, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

Sharing your information

The Interoperability and Patient Access rule (CMS-9115-F) was passed in 2020 by the Centers for Medicare and Medicaid Services (CMS). The rule makes it easier for you to access and share your health data. For example, use your smart phone app to find out about claims, medications and more. This shared data is found with certain insurance plans. Apps can get information starting from 2016. The year apps can start collecting health data is based on when you enrolled in your current plan. Why share data between you, health care providers and the apps? It helps everyone work together to improve patient care. This may help reduce your health care costs, too.

Third party app

Protect your health information. This is information about you and your health. Your privacy is important. Third-party apps may collect your health information. Third-party means the app is not ours. The app is not working for us. Make sure you understand your apps. Read their privacy policies. Choose apps with strong privacy and security. If you believe an app has improperly used your information:

- You can file a complaint with the Health and Human Services Office for Civil Rights (OCR). Use the OCR complaint portal.
- You can file a complaint with the FTC. Use the FTC complaint assistant.

No charge to you

UnitedHealthcare does not charge our members for access to the Patient Access API and Provider Directory API under The Interoperability and Patient Access rule (CMS-9115-F).

Glossary

Aged, Blind, or Disabled (ABD): A category of eligibility under the State Plan for persons who are aged (sixty-five (65) years of age or older), legally blind, and/or disabled.

Abuse: Any practices, processes or actions by the health plan or provider that are not consistent with sound fiscal, business, or medical practice resulting in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or State and Federal requirements. This includes any actions or decisions by a member that may result in unnecessary cost to the Medicaid program.

Acute care: Short-term medical treatment provided under the direction of a physician, usually in an acute care hospital for members having an acute illness or injury.

Adult: QUEST Integration members age twenty-one (21) years or older for coverage benefit purposes only.

Adverse benefit determination: A decision your health plan can make to deny, restrict, reduce, limit, suspend or terminate services previously authorized. This includes a denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, co-insurance, and other member financial liabilities.

Annual plan change period: A period when an eligible individual is allowed to change from one participating health plan to another participating health plan.

Appeal: A review by the health plan and State Administrative Appeal of an adverse benefit determination.

Authorized representative: An individual or organization designated by the member, in writing, with the designee's signature or by legal documentation or authority to act on behalf of a member in compliance with federal and state laws or regulations. Member may choose an authorized representative at any time.

Beneficiary: Any person determined eligible for Medicaid benefits by the Department of Human Services (DHS).

Benefits: The health services you can get under the QUEST Integration program.

Benefit year: A continuous twelve (12) month period generally following an open enrollment period. In the event that the current benefit period is not in effect for the full benefit year, any benefit limits will be pro-rated.

Care team: A team of health care professionals from different professional disciplines who work together to manage the physical, behavioral health, and social needs of the member.

Centers for Medicare and Medicaid Services (CMS): The United States federal agency which administers the Medicare program and, working jointly with the state governments, the Medicaid program, and the State Children's Health Insurance Program (SCHIP).

Children's Health Insurance Program (CHIP) or State Children's Health Insurance program (SCHIP): A joint federal-state health care program for uninsured, targeted, low-income children that is part of the Medicaid expansion program in Hawaii.

Child: QUEST Integration members under the age of twenty-one (21) for coverage benefit purposes only.

Claim: A document which is submitted by a provider to the health plan for payment of health-related services rendered to a member.

Clean claim: A claim that can be processed without requiring additional information from the provider. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Copayment: A specific dollar amount or percentage of the charge you pay at the time of service to a health care plan, physician, hospital or other provider of care for covered services.

Cost-sharing, share of cost or cost share: An amount that you pay to your health care provider or the health plan as part of your share in the cost of your health care eligibility. This amount is determined by your Department of Human Services Case Worker.

Cultural competency: A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among, and between groups and sensitivity to know how these differences influence relationships with members. This requires a willingness and ability to draw on community-based values, traditions and customs to come up with strategies to better understand and meet member needs.

Department of Human Services (DHS): The agency that is responsible for providing public assistance programs to the population it serves.

Dual eligible: A member that is eligible for both Medicare and Medicaid.

Durable Medical Equipment (DME): Equipment that is primarily and customarily used for a medical purpose. Examples of DMEs are oxygen tanks and concentrators, ventilators, wheelchairs, hospital beds, and orthotic devices.

Emergency medical condition: One with sudden, severe symptoms that without immediate care could result in placing one's health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, serious harm to self or bodily harm to others due to an alcohol or drug abuse emergency, or injury to self or bodily harm to others. In the case of a pregnant woman, serious jeopardy to the woman or her unborn child.

Emergency medical transportation: Transportation that is provided due to an emergency condition. Service includes ground and air transportation.

Emergency room care: Care that is available in an emergency room 24 hours a day, 7 days week and without a prior authorization to treat a life-threatening or very severe illness.

Emergency services: Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard (an individual who does not have medical training).

Excluded services: Health care services that are not covered by QUEST Integration.

Enrollment fee: The amount a member is responsible to pay that is equal to the spenddown amount for a medically needy individual or cost share amount for an individual receiving long term services and supports. A resident of an intermediate care facility for intellectual/development disability (I/DD) or a participant in the Medicaid waiver program for individuals with developmental disabilities or intellectual disabilities are exempt from the enrollment fee.

Grievance: An expression of dissatisfaction from a member, member's representative, or provider on behalf of a member about any matter other than an adverse benefit determination. Examples of something that you might not be happy about are: issues with quality of service or care, how we or your provider run their office, if we or your provider was rude, wait times during appointment visits or not getting the information you need.

Habilitation services and devices: Services and devices to develop, improve, or maintain skills and functioning for daily living that were never learned or acquired to an appropriate level.

Health Action Plan (HAP): A person-centered individualized plan that is developed with the member and/or authorized representative based on the member's health care needs (i.e., special health care needs, expanded health care needs or long-term services and supports needs).

Health insurance: Any health insurance program for which a person pays for insurance benefits directly to the carrier, participation through an employer or union sponsored program or participation through a federal or state program (such as Medicaid).

Health plan: A plan offered by an insurance company or other organization, which provides different health care benefit packages.

Home health care: Services provided in a home and includes medical equipment and supplies, therapy or rehabilitative services, skilled nursing care and home health aides.

Hospice services: Care if you are terminally ill and are expected to live less than six months.

Hospitalization: An admission to a hospital for treatment. This includes admission to an acute care hospital, critical acute care hospital or psychiatric hospital.

Hospital outpatient care: Medical care treatment that does not require overnight stay in a hospital or medical facility. Services include but are not limited to oncology services, respiratory services, cardiology services and other medically necessary services.

Indian: The term "Indians" or "Indian," unless otherwise designated, means any person who is a member of an Indian tribe except that, for the purpose of sections 1612 and 1613 of title 25 of the U.S. Code, such terms shall mean any individual who:

- Regardless of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; or
- Is an Eskimo or Aleut or other Alaska Native; or
- Is considered by the Secretary of the Interior to be an Indian for any purpose, or is determined to be an Indian under regulations specified by the Secretary of Health and Human Services.

Indian Health Care Provider (IHCP): A health care program operated by the Indian Health Services (IHS) or by an Indian tribe, tribal organization, or urban Indian organization (otherwise known as an I/T/U).

Indian Tribe: The term "Indian Tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Medicaid: Medical assistance provided under a State plan approved under Title XIX of the Social Security Act. This includes the medical care and long-term care services for eligible individuals.

Medical necessity: Services that are recommended by your doctor and approved by your plan's medical director and are:

- For the purpose of treating a medical condition;
- The most appropriate delivery or level of service, considering potential benefits and harms to you;
- Known to be effective in improving health outcomes;
  - Effectiveness is determined first by scientific evidence;
  - If no scientific evidence exists, then by professional standards of care; and
  - If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and
- The treatment is cost effective for the medical condition being treated compared to alternative health interventions, including no intervention. Cost effective does not necessarily mean the lowest price.

Medicare: The health care insurance program for the aged and disabled that is administered by the Social Security Administration.

Network: Doctors, nurses, physician assistants and other health care providers such as hospitals, skilled nursing facilities, and long-term services and supports providers who are contracted with UnitedHealthcare to give your health care services.

Non-participating provider: A provider such as a doctor, nurse, physician assistant and other health care providers that do not have a contract with UnitedHealthcare to give your health care services.

Physician services: Health care services that are provided by a doctor.

Post-stabilization services: Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

Preauthorization: Preauthorization is also called prior authorization. Prior authorization is when you need permission from your health plan to get certain health care services.

Participating provider: A provider such as a doctor, nurse, physician assistant and other health care providers that have a contract with UnitedHealthcare to give your health care services.

Premium: An amount to be paid for an insurance policy or plan.

Other plan details

Prescription drug coverage: Part of health insurance that pays a partial amount of the cost of medication prescribed by a doctor.

Prescription drugs: Medicine that is ordered or prescribed by your doctor and includes medication management and patient education.

Primary Care Provider (PCP): A personal health care provider or primary care physician who will make sure that you get all the care you need to stay healthy. The PCP must be licensed in the State of Hawai‘i and can be a physician, either an M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy), a family practitioner, general practitioner, general internist, pediatrician or obstetrician/gynecologist (for women, especially pregnant women), or an advanced practice registered nurse with prescriptive authority or a licensed physician assistant.

Provider: An individual, clinic, institution, referral specialists and hospitals responsible for providing health care services under a health plan.

Rehabilitation services and devices: Services provided at a rehabilitation hospital and includes physical and occupational therapy, and speech-language pathology to help restore function lost or impaired due to illness or injury. Services are provided by licensed health care therapists.

Skilled nursing care: Level of care provided by licensed nursing professionals in a nursing facility to members who need 24-hour-a-day help with daily living on a regular, long-term basis.

Social Determinants of Health (SDOH): Conditions in which individuals are born, grow, live, work, and age that shape health. Examples of determinants of health include but are not limited to Socio-economic status, discrimination, education, neighborhood and physical environment, employment, housing, food security and access to health food choices, access to transportation, social support networks and connection to culture, as well as access to health care.

Specialist: A doctor that treats a special health problem, like an allergy doctor or a heart doctor.

Telehealth/Telemedicine: The use of telecommunications services that includes store and forward technologies, remote monitoring, live consultation, and mobile health. Service delivery includes but is not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information.

Third Party Liability (TPL): TPL refers to any other health insurance plan or carrier, such as an individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance, and worker's compensation or program that is, or may be, liable to pay all or part of the health care expenses of the member.

Urgent Care: Care that is needed sooner than a normal appointment (one calendar day) for medical conditions that are serious but not life threatening.

Frequently Asked Questions (FAQ)

Health Coordinator/Care Manager

Go to pages 29–31 if you need help or have the following questions:

- How can I get a Health Coordinator or Care Manager?
- How will I know that I have a Health Coordinator or Care Manager?
- How can I connect with my Health Coordinator or Care Manager?
- Can I change my Health Coordinator or Care Manager?
- What if I don't want or no longer want a Health Coordinator or Care Manager?
- How can I request for services in my home such as help with cleaning, cooking, shopping, and running errands?

Transportation

Go to pages 140–141 if you have the following transportation questions:

- How do I schedule a ride?
- How can I confirm my pick-up time?
- Why is my ride late?
- How can I get passes for the Handi-Van?
- How do I get passes for the bus?

Inter-island and out-of-state travel

Go to page 144 if you have the following questions:

- How can I get services from a doctor that is on another island?
- How can I get services from a doctor that is in another state?
- How can I arrange for my travel (air/ground transportation) if I need to see a doctor who is on another island or in another State?
- Does my insurance pay for my meals and lodging?
- When will I get a copy of my itinerary for my travel to another island or to another state?
- I can't travel alone because of a medical condition, how can I get a companion or escort to travel with me?

Self-Direct services or directing my own care

Go to page 91 if you need help with Self-Direct services or have the following questions:

- What is Self-Direct?
- How do I qualify for Self-Direct services?
- Who can be my Self-Direct provider?
- How or when do Self-Direct Providers get paid?

Behavioral Health Field Advocate/Peer Specialist

Go to page 28 if you need help with getting behavioral health services or if you have questions:

- How can I get a Behavioral Health Field Advocate?
- Is there a Peer Specialist that I can talk to?
- I need help finding a counselor or doctor
- I am having mental health issues
- I am having issues with drugs and alcohol
- I need help with food
- I need help with a place to live
- I am in a crisis, how can I get help?

Hearing aid devices

Go to page 64 if you have the following questions about hearing aid devices:

- How can I get a hearing aid device?
- How often can I get a hearing aid device?
- What providers do I call to get a hearing aid device?

Medicaid dental benefits for children

Go to pages 55, 95, and 114 for more information about dental coverage for children or if you need help or have the following questions:

- Does my child's insurance cover dental services?
- What kind of dental services can my child get?
- How can my child get a ride to dental appointments?

Medicaid dental benefits for adults

Go to pages 55 and 114–116 for more information about adult dental benefits or if you have the following questions:

- Does my insurance cover adult dental services?
- What if I have dental coverage through my Medicare or other insurance plan?
- What kind of dental emergencies are covered?
- Does my insurance have any special dental benefits for adults?

Incontinence supplies (diapers, underpads, liners)

Go to page 58 for information or if you have the following questions:

- How can I place an order for diapers?
- How can I update the mailing address that my order was sent to?
- Who do I call if my order is late or if my order is not received?
- Who do I call if my order was sent to the wrong address?

Health products catalog, gym/fitness program benefits, dentures

Go to page 23 if you have the following questions and have a UnitedHealthcare DSNP Medicare plan or if your Medicare coverage is through another health plan:

- How can I get a Health Products Catalog?
- Where can I go for my Gym or Fitness Program benefits?
- Are dentures covered?
- How can I change my Medicare plan to UnitedHealthcare DSNP plan?

Address/phone number/email and other changes

Go to pages 14 and 156 if you have the following questions:

- I moved to a new home — How can I update my residential address?
- How can I update my mailing address?
- My phone number changed — How can I update my phone number?
- Can you update my email address in your system?
- I now work part-time, how can I update my records?
- I lost my part-time job-Who do I need to report this change to?
- How can I update my language preference in your system?

Plan change/disenrollment requests

Go to pages 14–15 if you have the following questions:

- How can I disenroll from the QUEST Integration program?
- How can I change my QUEST Integration plan to UnitedHealthcare (or change from UnitedHealthcare to another QUEST Integration plan)?
- Why did I lose my UnitedHealthcare QUEST Integration coverage?
- Can you help me get my Medicaid coverage reinstated?

High Prescription Utilization Program

Go to page 148 if you have the following questions:

- Why is the pharmacy telling me that I can only go to another pharmacy to get my prescriptions filled?
- Why is there a lock or block on my prescription?
- What can I do to change the pharmacy that I can go to for my prescriptions?
- What is medication assisted treatment services?

Share of cost (enrollment fee, cost share)

Go to pages 39–41 if you have the following questions:

- What is a share of cost?
- Why am I receiving a bill or invoice for a share of cost?
- My share of cost amount is not correct who can I talk to about this?

Not covered or excluded services

Go to page 109–112 if you have the following questions:

- How can I find out what's not covered by my plan?
- What do I do if my doctor says that I need a procedure that might not be covered by my plan?

We are here when you need us

When you or a family member are sick or injured, it can be difficult to make health care decisions.

- Do I need to go to the emergency room?
- Should I go to urgent care?
- Can I wait and make a Primary Care Provider (PCP) appointment?
- Could I take care of this fever myself?

UnitedHealthcare Community Plan members have access to an experienced NurseLine nurse who can give you information to help you make those hard decisions.

Nurses are available 24 hours a day, 7 days a week.

We're here to help.
Call toll-free **1-888-980-8728**, TTY **711** | Visit **myuhc.com/CommunityPlan**

United Healthcare
Community Plan

What is EPSDT?

Early Periodic Screening Diagnostic Treatment

It will help keep your child healthy

EPSDT has many names:

- Well checkup
- Preventive health screening
- Wellness checkup
- EPSDT checkup

Why it's important:

- Find out about a medical problem earlier
- Stop a medical condition from getting worse
- Get referrals to specialists or community services
- Stop the development of chronic conditions
- For autism and developmental screening

When to see your PCP:

- 14 days old
- 30 days old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old
- 24 months old
- 30 months old
- 36 months old
- Schedule a visit once a year after 3 years old

Visit your Primary Care Provider (PCP) when recommended to keep your child healthy.

United Healthcare
Community Plan