Section 3 – Physical health services

Covered services

The chart below lists the services that are covered by UnitedHealthcare Community Plan when the services are medically necessary. Some of the services have limits or co-payments, or need a referral from your PCP or require prior authorization by UnitedHealthcare Community Plan. If you need services beyond the limits listed below, your provider can sometimes ask for an exception, as explained below in this section. Limits do not apply if you are under age 21 or pregnant.

Service		Children	Adults
Primary Care Provider	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Specialist	Limit	None	None
	Co-Payment	None	$1
	Prior Authorization	Referral from PCP except for dental, family planning, vision care, chiropractic services, or OB/GYN services.	Referral from PCP except for dental, family planning, vision care, chiropractic services, or OB/GYN services.
Certified Registered Nurse Practitioner	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None

Service		Children	Adults
Federally Qualified Health Center/ Rural Health Center	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Outpatient Non-Hospital Clinic	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Outpatient Hospital Clinic	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Podiatrist Services	Limit	None	None
	Co-Payment	None	$1
	Prior Authorization	May require prior authorization.	May require prior authorization.
Chiropractor Services	Limit	None	None
	Co-Payment	None	$1
	Prior Authorization	None	None
Optometrist Services	Limit	2 visits/year	2 visits/year
	Co-Payment	None	None
	Prior Authorization	None	None

Service		Children	Adults
Hospice Care	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	May require prior authorization.	May require prior authorization.
Dental Care Services	Limit	None	Dentures 1 per lifetime; Exams/prophylaxis 1 per 180 days; Crowns, periodontics and endodontics may be an available benefit if you meet one or more of the criteria listed on page 57 via an approved Benefit Limit Exception Form submitted by your dental provider.
	Co-Payment	None	None
	Prior Authorization	Prior authorization needed for some services.	Prior authorization needed for some services.
Radiology (ex. X-rays, MRIs, CTs)	Limit	None	None
	Co-Payment	None	$1
	Prior Authorization	Prior authorization required.	Prior authorization required.
Outpatient Hospital Short Procedure Unit	Limit	None	None
	Co-Payment	None	$3
	Prior Authorization	May require prior authorization.	May require prior authorization.

Service		Children	Adults
Outpatient Ambulatory Surgical Center	Limit	None	None
	Co-Payment	None	$3
	Prior Authorization	May require prior authorization.	May require prior authorization.
Non-Emergency Medical Transport	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	May require prior authorization. Some services provided by MATP. Please see page 74.	May require prior authorization. Some services provided by MATP. Please see page 74.
Family Planning Services	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Renal Dialysis	Limit	None	Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year.
	Co-Payment	None	None
	Prior Authorization	None	None

Service		Children	Adults
Emergency Services	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Ambulance Services	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Inpatient Hospital	Limit	None	None
	Co-Payment	None	$3 per day, up to $21 maximum per stay.
	Prior Authorization	Prior authorization needed for non-emergent admission.	Prior authorization needed for non-emergent admission.
Inpatient Rehab Hospital	Limit	None	None
	Co-Payment	None	$3 per day, up to $21 maximum per stay.
	Prior Authorization	Prior authorization required.	Prior authorization required.
Maternity Care	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None

Service		Children	Adults
Prescription Drugs	Limit	None	None
	Co-Payment *Some drugs do not have a co-payment. See **Prescriptions** section.	None	Brand: $3, Generic: $1
	Prior Authorization	Prior authorization required on some medications. See **Prescriptions** section.	Prior authorization required on some medications. See **Prescriptions** section.
Enteral/ Parenteral Nutritional Supplements	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	May require prior authorization.	May require prior authorization.
Nursing Facility Services	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	Prior authorization required.	Prior authorization required.
Home Health Care Including Nursing, Aide, and Therapy Services	Limit	None	Unlimited first 28 days; 15 days per month following.
	Co-Payment	None	None
	Prior Authorization	Prior authorization required.	Prior authorization required.

Service		Children	Adults
Durable Medical Equipment	Limit	None	None
	Co-Payment	None	$1 limit to $3 max
	Prior Authorization	May require prior authorization if over $500.	May require prior authorization if over $500.
Prosthetics and Orthotics	Limit	None	Orthopedic shoes and hearing aids are not covered. Coverage for low vision aids is limited to 1 per 2 calendar years. Coverage for an eye ocular is limited to 1 per calendar year.
	Co-Payment	None	$1 limit to $3 max
	Prior Authorization	May require prior authorization if over $500.	May require prior authorization if over $500.
Eyeglass Lenses	Limit	Members under age 21 are covered for 4 lenses per year. Regular single vision, bifocal or trifocal lenses. Polycarbonate lenses: Covered.	Members age 21 and over are covered for 2 lenses per year. Regular single vision, bifocal or trifocal lenses. Polycarbonate lenses: Covered for adults who are blind in one eye and +/-6.00 prescription.
	Co-Payment	None	None
	Prior Authorization	None	None

Service		Children	Adults
Eyeglass Frames	Limit	Members under age 21 are covered for 2 frames per year. In-plan frames are covered in full. Out-of-plan frames are covered up to $20; member must pay cost over $20.	Members age 21 and over are covered for 1 frame per year. In-plan frames are covered in full. Out-of-plan frames are covered up to $20; member must pay cost over $20.
	Co-Payment	Out-of-plan frames are covered up to $20; member must pay cost over $20. This allowance applies at retail locations such as Walmart, and may not be available at independent provider locations.	Out-of-plan frames are covered up to $20; member must pay cost over $20. This allowance applies at retail locations such as Walmart, and may not be available at independent provider locations.
	Prior Authorization	None	None

Service		Children	Adults
Contact Lenses	Limit	One pair soft daily wear contacts or medically necessary contacts covered in lieu of glasses, including contact lens exam/evaluation. Medically necessary contact lenses are covered when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to, the diagnosis of: Unilateral Aphakia; or Keratoconus when vision with glasses is less than 20/40; or Corneal transplant when vision with glasses is less than 20/40; or Anisometropia that is greater than or equal to 4.00 diopter. Medically necessary exceptions can be made for children under 21.	One pair soft daily wear contacts or medically necessary contacts covered in lieu of glasses, including contact lens exam/evaluation. Medically necessary contact lenses are covered when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to, the diagnosis of: Unilateral Aphakia; or Keratoconus when vision with glasses is less than 20/40; or Corneal transplant when vision with glasses is less than 20/40; or Anisometropia that is greater than or equal to 4.00 diopter.
	Co-Payment	None	None
	Prior Authorization	None	None

Service		Children	Adults
Medical Supplies	Limit	None	None
	Co-Payment	None	$1 limit to $3 max
	Prior Authorization	None	None
Therapy (Physical, Occupational, Speech)	Limit	None	None
	Co-Payment	None	$1
	Prior Authorization	None	None
Laboratory	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Tobacco Cessation	Limit	None	70 visits per calendar year.
	Co-Payment	None	Brand: $3, Generic: $1
	Prior Authorization	None	None
Abortions	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	Must meet current federal and state guidelines and be medically necessary.	Must meet current federal and state guidelines and be medically necessary.

Service		Children	Adults
Allergy Testing	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Audiology	Limit	None	Hearing aides are not covered.
	Co-Payment	None	None
	Prior Authorization	None	None
Autism Services	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	May require prior authorization.	May require prior authorization.
Birth Control Services	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Diabetic Education, Home Visits and Monitoring	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Diabetic Supplies and Equipment	Limit	None	None
	Co-Payment	None	$1 limit to $3 max
	Prior Authorization	None	None

Service		Children	Adults
EPSDT Services	Limit	None	Not Covered
	Co-Payment	None	Not Covered
	Prior Authorization	None	Not Covered
Hearing Aids and Batteries	Limit	None	Not Covered
	Co-Payment	None	Not Covered
	Prior Authorization	Prior authorization required.	Not Covered
Hearing Exams	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Immunizations	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Incontinence Supplies	Limit	None	None
	Co-Payment	None	$1 limit to $3 max
	Prior Authorization	None	None
Mammograms	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None

Service		Children	Adults
Organ Transplant Evaluation	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	Prior authorization required.	Prior authorization required.
Orthodontia	Limit	None	Not Covered
	Co-Payment	None	Not Covered
	Prior Authorization	Prior authorization required.	Not Covered
Pain Management	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	May require prior authorization.	May require prior authorization.
Shift Care/ Private Duty Nursing	Limit	None	Not Covered
	Co-Payment	None	Not Covered
	Prior Authorization	Prior authorization required.	Not Covered
Second Opinions (Medical and Surgical)	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None
Urgent Care	Limit	None	None
	Co-Payment	None	None
	Prior Authorization	None	None

Services that are not covered

There are physical health services that UnitedHealthcare Community Plan does not cover. If you have any questions about whether or not UnitedHealthcare Community Plan covers a service for you, please call Member Services at **1-800-414-9025**, TTY/PA Relay **711**.

- Experimental medical procedures, medicines, and equipment
- Care from doctors that are not covered by your health insurance who are not prior-approved, except for emergency or family planning services
- Services covered by other insurance, workers' compensation or programs like Veterans Administration
- Boarding home expenses (residential care that is not medically necessary)
- Infertility services
- Skilled nursing or intermediate care facilities over 30 consecutive days for members outside of Community Health Choices areas. See page 73.
- Personal convenience items (telephone, television, etc.) while in a hospital room, unless medically necessary
- Plastic or cosmetic surgery, except in case of injury or surgery that causes disfigurement
- Services that are not medically necessary
- Custodial Services
- Home-Delivered Meals
- Personal Emergency Response Systems

Second opinions

You have the right to ask for a second opinion if you are not sure about any medical treatment, service, or non-emergency surgery that is suggested for you. A second opinion may give you more information that can help you make important decisions about your treatment. A second opinion is available to you at no cost other than a co-pay.

Call your PCP to ask for the name of another UnitedHealthcare Community Plan network provider to get a second opinion. If there are not any other providers in UnitedHealthcare Community Plan's network, you may ask UnitedHealthcare Community Plan for approval to get a second opinion from an out-of-network provider.