



# Covered Benefits – Rhody Health Partners

## Benefits Covered by UnitedHealthcare Community Plan

As member of UnitedHealthcare Community Plan, you are covered for the following services. (Remember to always show your current member ID card when getting services. It confirms your coverage.) If a provider tells you a service is not covered by UnitedHealthcare and you still want these services, you may be responsible for payment. You can always call Member Services at **1-800-587-5187, TTY: 711**, to ask questions about benefits.

### Rhody Health Partners.

Benefit	Coverage
<b>Abortion Services</b>	Not covered, except to preserve the life of the woman, or in cases of rape or incest.
<b>Adult Day Services</b>	Covered when ordered by a network physician.
<b>Alcohol and Substance Abuse Treatment</b>	<b>Inpatient:</b> Covered. Includes day treatment, partial hospitalization and residential treatment, except for residential treatment for children ordered by the Department of Children, Youth and Families (DCYF), and except for residential substance abuse treatment for children ages 13 to 17. Covered residential treatment services exclude room and board. (Butler Hospital may be used for services.) <b>Outpatient:</b> Covered. Includes methadone maintenance, outpatient methadone detoxification, collateral visits and court-ordered services provided by a network provider.
<b>Cosmetic Surgery</b>	Not covered, except medically necessary surgery to treat illness or injury to restore or provide function. Breast reconstruction following a mastectomy is covered.

## Benefits

Benefit	Coverage
<b>Dental Care</b>	<b>Emergency:</b> Covered. Emergency care to control pain, bleeding, infection or accidental injury. <b>Routine:</b> Covered. Checkups and treatment using your Medicaid card.
<b>Diabetes</b>	Covers education, visits and supplies (glucose meters, test strips, lancets, insulin inject aids, syringes and molded shoes).
<b>Dialysis</b>	Covered.
<b>Drugs</b> (prescription and over-the-counter)	Covered. Generic substitution required unless otherwise ordered by a network provider. Prior authorization for some prescription drugs. Many over-the-counter drugs are covered, including nicotine cessation. Not covered: Medications for sexual or erectile dysfunction are not covered.
<b>Durable Medical Equipment (DME)</b>	Covered when ordered by a network physician. Includes surgical appliances, prosthetic devices, orthotic devices, assistive technology and medical supplies as covered by the Medicaid program.
<b>Education Classes</b> (childbirth, parenting, smoking cessation, diabetes, asthma, nutrition, etc.)	Covered.
<b>Emergency Room Services</b>	Covered.
<b>Emergency Transportation</b>	Covered.
<b>Experimental Procedures</b>	Not covered, except when a state mandate for coverage exists.
<b>Eye Care</b>	<b>For adults:</b> Covered. Routine eye exams, including refractions, and one pair of glasses, as needed, in a two-year period. Exams and treatment for illness or injury as ordered by your PCP. Annual eye exams and eyeglass lenses for members who have diabetes; frames are covered only every two years.

# Benefits

Benefit	Coverage
<b>Family Planning Methods</b> (prescription and nonprescription)	Covered. Limited to twelve 30-day supplies per year. Covered contraceptives include oral contraceptives, IUD, cervical cap, diaphragm and Depo-Provera. Covered nonprescription methods include foam, spermicidal jelly and condoms. Emergency contraceptives as needed. Sterilization is covered in many cases. Must meet state and federal guidelines and have Rhode Island Medicaid Consent Form signed at least 30 days prior.
<b>Family Planning Services</b>	Enrolled female members have freedom of choice of providers of family planning services.
<b>Hearing Therapy</b>	Covered.
<b>Home Health Care Therapy and Services</b>	Covered when ordered by a network provider.
<b>Hospice Care</b>	Covered when ordered by a network physician, up to 210 days lifetime maximum for palliative treatment only.
<b>Hospital Care</b>	Covered. Private room not covered unless medically necessary.
<b>Infertility Treatment</b>	Not covered.
<b>Interpreters</b>	Covered. Call Member Services. Requires 72-hour notice. Sign language services require two weeks' notice.
<b>Laboratory Tests</b>	Covered when ordered by network provider.
<b>Language Therapy</b>	Covered when ordered by your PCP.
<b>Medical Equipment</b>	Covered when ordered by network provider.
<b>Mental Health</b> (inpatient and outpatient)	Covered. Member may self-refer for outpatient services to a network provider. Includes day and residential treatment. Requires prior authorization from Optum Behavioral Health at <b>1-800-435-7486</b> . Butler Hospital may be used for services.

## Benefits

Benefit	Coverage
<b>Nonemergency Medical Transportation</b>	Covered with a RIPTA No Fare ID Pass to ride RIPTA buses or other appropriate transportation through the Medicaid Transportation Line.
<b>Nursing Homes</b> (skilled nursing facility)	Covered when ordered by a network provider.  Rhody Health Partners are covered for 30 consecutive days. If services are required beyond 30 consecutive days, see “Out-of-Plan Benefits.”
<b>Nutrition Counseling</b>	Covered when ordered by network provider. Referrals to licensed dietitian only.
<b>Outpatient Hospital Services</b> (including physical, occupational, hearing, respiratory and language therapy)	Covered when ordered by a network provider. Includes covered services delivered in an outpatient hospital setting.
<b>Outpatient Imaging</b>	Covered. MRIs, MRAs, and CT and PET scans are covered with prior authorization.
<b>Outpatient Rehab Services</b> (cardiac, physical, occupational and speech)	Covered when ordered by network provider.
<b>Physician Services</b>	Covered. Including anesthesia for dental and oral surgery including temporomandibular joint (TMJ). Up to one annual visit and five GYN visits annually to a network provider for family planning (covered without a referral from a PCP). Immunizations and vaccines covered (except for travel).
<b>Post-Stabilization Care Services</b>	Covered per services related to an emergency medical condition that are provided after the condition is stabilized.
<b>Podiatry (foot) Care</b>	Covered when ordered by a network provider.
<b>Pregnancy Care</b>	Covered, including postpartum care, lactation services and breast pumps.

## Benefits

Benefit	Coverage
<b>Private Hospital Rooms</b>	Not covered unless medically necessary.
<b>Services of Other Practitioners</b>	Covered if referred by an in-network provider. Practitioners certified and licensed by the state of Rhode Island including nurse practitioners, physicians' assistants, social workers, licensed dietitians, psychologists and licensed nurse midwives.
<b>Services Outside of Rhode Island</b>	Not covered unless from a network provider or if a covered benefit is not available in-network.
<b>Services Outside of the United States</b>	Not covered.
<b>Surgery</b> (ambulatory, emergency, inpatient and reconstructive)	Covered when ordered by a network provider. Emergency surgery is covered. Second surgical opinions are covered.
<b>Testing</b> (diagnostic)	Lab (blood and urine test, etc.), X-ray and other diagnostic tests covered when ordered by a network provider.
<b>Transplant Services</b>	Covered when ordered by a network physician.