Member Handbook for 2026

UHC Senior Care Options (HMO D-SNP)

myUHC.com/CommunityPlan

Toll-free **1-888-867-5511**, TTY **711**
8 a.m.–8 p.m. local time, 7 days a week

United Healthcare
Community Plan

H2226_001_H2226_002_2026_EOC_C
UHSCO_H2226_001_H2226_002_2026_EOC_C

UnitedHealthcare® SCO Member Handbook

January 1, 2026 – December 31, 2026

Your Health and Drug Coverage under UHC Senior Care Options (HMO D-SNP)

Member Handbook introduction

This **Member Handbook**, otherwise known as the **Evidence of Coverage**, tells you about your coverage under our plan through December 31, 2026. It explains health care services, behavioral health (mental health and substance use disorder) services, drug coverage, and long-term services and supports. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this **Member Handbook**.

This is an important legal document. Keep it in a safe place.

When this **Member Handbook** says “we”, “us”, “our”, or “our plan”, it means UHC Senior Care Options (HMO D-SNP).

This document is available for free in multiple languages.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

You can call the Member Services and ask us to make a note in our system that you would like this document in Spanish, large print, braille, or audio now and in the future.

Disclaimers

- Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan’s contract renewal with Medicare.
- UHC Senior Care Options is a Dual Special Needs Plan (D-SNP) with a Medicare contract and a contract with the Commonwealth of Massachusetts Medicaid program. Enrollment in the plan depends on the plan’s contract renewal with Medicare.
- UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.
- Benefits may change on January 1, 2026
- Our formulary, pharmacy network, and provider network can change at any time. You’ll get notice about any changes that can affect you at least 30 days in advance.
- **Estate Recovery Awareness:** MassHealth (Medicaid) is required by federal law to recover money from the estates of certain MassHealth (Medicaid) members who are age 55 years or older, and who are any age and are receiving long-term care in a nursing home or other medical institution. For more information about Massachusetts MassHealth (Medicaid) estate recovery, please visit www.mass.gov/estaterecovery.

OMB Approval 0938-1444 (Expires: June 30, 2026)

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Chapter 1

Getting started as a member

Chapter 1

Getting started as a member

Introduction

This chapter includes information about **UHC Senior Care Options (HMO D-SNP)**, a health plan that coordinates all of your Medicare and MassHealth (Medicaid) services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

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Section A Welcome to our plan

UHC Senior Care Options MA-Y001 (HMO D-SNP), UHC Senior Care Options NHC MA-Y002 (HMO D-SNP) is a Senior Care Option (SCO): MassHealth plus Medicare plan. A SCO plan is made up of doctors, hospitals, pharmacies, providers of Long-term Services and Supports (LTSS), mental health providers, substance use disorder providers, community-based organizations that can assist with health-related social needs, and other health care providers. In a SCO plan, a Care Manager will work with you to develop a plan that meets your specific health needs. A Care Manager will also help you manage all your providers, services, and supports. They all work together to give you the care you need.

SCO is a program run by Massachusetts and the federal government to provide better health care for people who have both Medicare and MassHealth (Massachusetts Medicaid).

Section B Information about Medicare and MassHealth (Medicaid)

Section B1 Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

Section B2 MassHealth (Medicaid)

MassHealth is the name of Massachusetts Medicaid program. MassHealth (Medicaid) is run by Massachusetts and is paid for by Massachusetts and the federal government. MassHealth (Medicaid) helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the Commonwealth of Massachusetts approved our plan. You can get Medicare and MassHealth (Medicaid) services through our plan as long as:

- you're eligible to participate in SCO;
- we offer the plan in your county, **and**
- Medicare and the Commonwealth of Massachusetts allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and MassHealth (Medicaid) services isn't affected.

Section C Advantages of this plan

You'll now get all your covered Medicare and MassHealth (Medicaid) services from our plan, including drugs. **You don't pay extra to join this health plan.**

We help make your Medicare and MassHealth (Medicaid) benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a Care Manager. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You have access to a Geriatric Support Services Coordinator (GSSC). This is a person who will help you find and get community long-term care and social support services.
  - Both the Care Manager and GSSC work with your Care Team to make sure you get the care you need.
- You're able to direct your own care with help from your care team and Care Manager.
- Your care team and Care Manager work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

Section D Our plan's service area

Our service area includes these counties in Massachusetts: **Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester.**

Only people who live in our service area can join our plan.

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this **Member Handbook** for more information about the effects of moving out of our service area.

Section E What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- are 65 or older
- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for MassHealth Standard, **and**
- aren't enrolled in a MassHealth Home and Community-based Services (HCBS) waiver; **and**
- have no other health insurance.

If you lose MassHealth (Medicaid) eligibility but can be expected to regain it within one month, then you are still eligible for membership in our plan. Call Member Services for more information.

Section F What to expect when you first join a health plan

When you first join our plan, you get a health risk assessment (HRA), also known as a "Comprehensive Assessment," within 90 days of your enrollment in the plan.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit in a location of your choosing, telephone call, or a virtual visit.

We'll send you more information about this HRA.

If UHC Senior Care Options (HMO D-SNP) is a new plan for you, you can keep using your doctors and getting your current services for 90 days or until your HRA and Individualized Care Plan (ICP) are complete. This is called the Continuity of Care period. If you're taking any Medicare Part D drugs when you join our plan, you can get a temporary supply. We'll help you to transition to another drug if necessary.

After the first 90 days, you'll need to use doctors and other providers in the UHC Senior Care Options (HMO D-SNP) network. A network provider is a provider who works with the health plan. Refer to **Chapter 3** more information on getting care from provider networks.

Section G Your care team and care plan

Section G1 Care team

A care team can help you keep getting the care you need and want. A care team may include your doctor, a Care Manager, or other health person that you choose. Together, you and your Care Team will make your individualized Care Plan.

A Care Manager is a person trained to help you manage the care you need and want. You get a Care Manager when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your Care Manager and care team.

Section G2 Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and long-term services and supports.

Your care plan includes: your list of health, independent living and recovery goals, as well as any concerns you may have and the steps needed to address them, **and**

- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. You'll be at the center of the process of making your care plan.

Every year, your care team will work with you to update your care plan in case there's a change in the health services you need and want. Your care plan can also be updated as your goals or needs change throughout the year.

Section H Your monthly costs for UHC Senior Care Options (HMO D-SNP)

Our plan has no premium.

Your costs may include the following:

- Monthly Medicare Part B Premium (**Section H1**)
- You will not pay any monthly premiums to UHC Senior Care Options for your health coverage. If you pay a premium to MassHealth (Medicaid) for MassHealth Standard, you must continue to pay the premium to MassHealth (Medicaid) to keep your coverage. Members who enter a nursing facility may have to pay a Patient Paid Amount to keep your MassHealth (Medicaid)

coverage. The Patient Paid Amount is the member's contribution to the cost of care in the facility. MassHealth (Medicaid) will send you a detailed notice should you be expected to pay a Patient Paid Amount.

- Optional Supplemental Benefit Premium (**Section H2**)

In some situations, your plan premium could be less.

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and SPAPs. *OR* The "Extra Help" program helps people with limited resources pay for their drugs. Learn more about these programs *OR* this program in **Chapter 2, Section H2**. If you qualify, enrolling in the program might lower your monthly plan premium.

If you already get help from one of these programs, **the information about premiums in this Member Handbook may *OR* does not apply to you.** We have included *OR* sent you a separate insert, called the "Member Handbook Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services at the number at the bottom of this page and ask for the "LIS Rider".

Section H1 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in **Section E** above to be eligible for our plan, you must maintain your eligibility for MassHealth (Medicaid) as well as have both Medicare Part A and Medicare Part B. For most UHC Senior Care Options (HMO D-SNP) members, MassHealth (Medicaid) pays for your Medicare Part A premium (if you don't qualify for it automatically) and Part B premium.

If MassHealth (Medicaid) isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. This includes your premium for Medicare Part B. **In addition, please contact Member Services or your Care Manager and inform them of this change.**

Section H2 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called "optional supplemental benefits", you pay additional premium each month for these extra benefits. Refer to **Chapter 4, Section E** for details.

Section I This Member Handbook

This **Member Handbook** is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of this **Member Handbook** or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a **Member Handbook** by calling Member Services at the numbers at the bottom of the page. You can also refer to the **Member Handbook** found on our website at the web address at the bottom of the page.

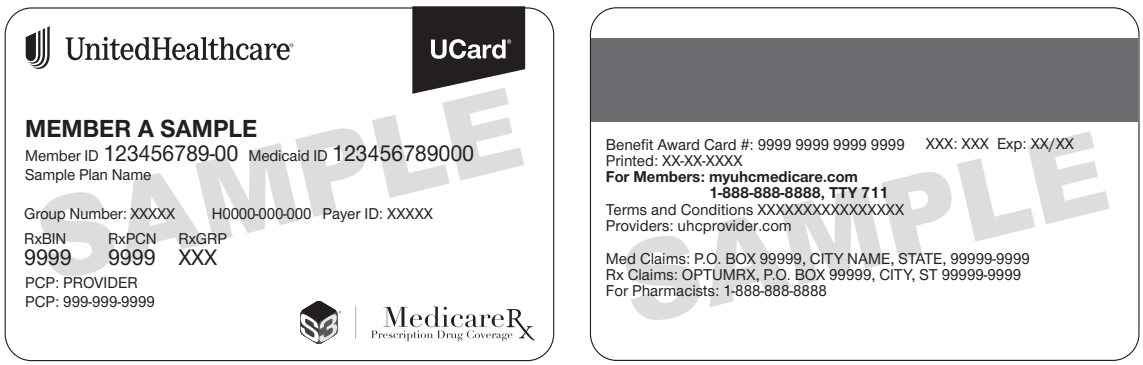
The contract is in effect for the months you're enrolled in our plan between January 1, 2026 and December 31, 2026.

Section J Other important information you get from us

Other important information we provide to you includes your UCard, information about how to access a **Provider and Pharmacy Directory**, a List of Durable Medical Equipment (DME), and information about how to access a **List of Covered Drugs**, also known as a **Drug List** or **Formulary**.

Section J1 Your UnitedHealthcare UCard®

Under our plan, you have one card for your Medicare and MassHealth (Medicaid) services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample UnitedHealthcare UCard®:



If your UnitedHealthcare UCard® is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We'll send you a new card.

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your MassHealth (Medicaid) card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your UCard, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this **Member Handbook** to find out what to do if you get a bill from a provider.

Section J2 Provider and Pharmacy Directory

The **Provider and Pharmacy Directory** lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a **Provider and Pharmacy Directory** (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the **Provider and Pharmacy Directory** at the web address at the bottom of the page.

Definition of network providers

- Our network providers include:
  - doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or MassHealth (Medicaid).

Network providers agree to accept payment from our plan for covered services as payment in full. You won't have to pay anything more for covered services.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the **Provider and Pharmacy Directory** to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

Section J3 List of Covered Drugs

Our plan has a **List of Covered Drugs**. We call it the **Drug List** for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The **Drug List** must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your **Drug List** unless they have been removed and replaced as described in **Chapter 5**. Medicare approved the UHC Senior Care Options (HMO D-SNP) **Drug List**.

The **Drug List** also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of this **Member Handbook** for more information.

Each year, we send you information about how to access the **Drug List**, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website at the address at the bottom of the page.

Section J4 The Explanation of Benefits

When you use your Medicare Part D drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D drugs. This summary is called the **Explanation of Benefits** (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take. **Chapter 6** of this **Member Handbook** gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

Section K How to keep your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

Section K1 Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of this **Member Handbook**.

Chapter 2

Important phone numbers and resources

Chapter 2

Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your Care Manager and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

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Section A Member Services

Method	Member services — Contact information
Call	**1-888-867-5511**. This call is free. Available 8 a.m.–8 p.m. local time, 7 days a week. We have free interpreter services for people who don't speak English.
TTY	**711** Calls to this number are free. Available 8 a.m.–8 p.m. local time, 7 days a week.
Write	UnitedHealthcare SCO Attention: Customer Service Department P.O. Box 30770 Salt Lake City, UT 84130-0770
Website	**myuhc.com/CommunityPlan**

Contact Member Services to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of this **Member Handbook**.
- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of this **Member Handbook** or contact Member Services.
- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a

complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).

- You can call us and explain your complaint at **1-888-867-5511**, TTY **711**.
- If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
- You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- You can also call My Ombudsman for help with **any** complaints or to help you file an appeal. (Refer to **Section G** for My Ombudsman's contact information.)
- To learn more about making a complaint about your health care, refer to **Chapter 9** of this **Member Handbook**.

• coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    • your benefits and covered drugs **or**
    • the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs, MassHealth (Medicaid) prescription drugs, and MassHealth (Medicaid) over-the-counter drugs.
  - For more on coverage decisions about your drugs, refer to **Chapter 9** of this **Member Handbook**.

• appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your drugs, refer to **Chapter 9** of this **Member Handbook**.

• complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your drugs, refer to **Chapter 9** of this **Member Handbook**.

- payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this **Member Handbook**.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this **Member Handbook**.

Section B Your Care Manager

Care Management is offered to all members of this plan. It includes a personalized approach by offering concierge services to support and guide members through the complexities of the healthcare system.

All members receive a care management service and an initial health screen. If additional needs are identified, a referral for a comprehensive needs assessment with a clinical Care Manager will be made.

All members:

- Are outreached for risk stratification and assessment
- Receive an individualized plan of care
- Have access to clinical care management programs, with a Care Manager assigned.

Method	Service Coordinator — Contact information
Call	**1-888-867-5511.** This call is free. 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept We have free interpreter services for people who don't speak English.
TTY	711. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Write	UnitedHealthcare Member Services Department PO Box 30769 Salt Lake City, UT 84130-0769
Website	**MyUHC.com/CommunityPlan**

Contact your Care Manager to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about transportation
- questions about getting medical services and long-term services and supports (LTSS)
- questions about getting help with food, housing, employment, and other health-related social needs
- questions about your care plan
- questions about approvals for services that your providers have requested

- questions about the benefits of Flexible Covered Services and how they can be requested

Section C SHINE (Serving the Health Insurance Needs of Everyone)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Massachusetts, the SHIP is called SHINE (Serving the Health Insurance Needs of Everyone).

SHINE is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Method	SHINE (Serving the Health Insurance Needs of Everyone) — Contact information
Call	1-800-AGE-INFO (1-800-243-4636), or locally 617-727-7750
TTY	1-800-439-2370 (Massachusetts only) This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Write	Call the number above for the address of the SHINE program in your area.
Website	www.mass.gov/health-insurance-counseling

Contact SHINE for help with:

- questions about Medicare
- SHINE counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - answer questions about switching plans,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

Section D Quality Improvement Organization (QIO)

Our state has an organization called Acentra Health. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Acentra Health is an independent organization. It's not connected with our plan.

Method	Acentra Health Services Line — Contact information
Call	1-888-319-8452
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	Acentra Health QIO 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609
Website	acentraqio.com

Contact Acentra Health for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care, such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

Section E Medicare

Medicare is the federal health insurance program for people 65 years of age or over, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & MassHealth (Medicaid) Services, or CMS. This agency contracts with Medicare Advantage organizations including our plan.

Method	Medicare — Contact information
Call	**1-800-MEDICARE (1-800-633-4227)** Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventative services (like screenings, shots, or vaccines, and yearly “wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

Section F MassHealth (Medicaid)

MassHealth (Massachusetts Medicaid) helps with medical and long-term services and supports costs for people with limited incomes and resources.

You're enrolled in Medicare and in MassHealth (Medicaid). If you have questions about the help you get from MassHealth, the contact information is below.

Method	MassHealth (Medicaid) — Contact information
Call	1-800-841-2900
TTY	711 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Write	MassHealth Customer Service 55 Summer Street Boston, MA 02110
Email	membersupport@mahealth.net
Website	www.mass.gov/masshealth

Section G Ombudsman

My Ombudsman is an independent program that can help you if you have questions, concerns, or problems related to Senior Care Options (SCO). My Ombudsman's services are free. My Ombudsman's staff:

- Can answer your questions or refer you to the right place to find what you need.
- Can help you address a problem or concern with SCO or your SCO plan, UHC Senior Care Options (HMO D-SNP). My Ombudsman's staff will listen, investigate the issue, and discuss options with you to help solve the problem.
- Help with appeals. An appeal is a formal way of asking your SCO plan, MassHealth (Medicaid), or Medicare to review a decision about your services. My Ombudsman's staff can talk with you about how to make an appeal and what to expect during the appeal process.
- You can call or write My Ombudsman. Please refer to the My Ombudsman website or contact them directly for updated information about location and walk-in hours.

Method	Ombudsman — Contact information
Call	1-855-781-9898 (Toll Free)
TTY	Use 7-1-1 to call 1-855-781-9898 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Videophone (VP): 339-224-6831 This number is for people who are deaf or hard of hearing.
Write	My Ombudsman 25 Kingston Street, 4th floor Boston, MA 02111
Email	info@myombudsman.org
Website	www.myombudsman.org

Section H Long-Term Care Ombudsman Program

The Long-Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

The Long-Term Care Ombudsman isn't connected with our plan or any insurance company or health plan.

Method	Long-Term Care Ombudsman — Contact information
Call	617-222-7495

Section I Programs to Help People Pay for Drugs

The Medicare website (www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your drug costs. For people with limited incomes, there are also other programs to assist, as described below.

Section I1 Extra Help from Medicare

Because you're eligible for MassHealth (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your drug plan costs. You don't need to do anything to get this "Extra Help."

Method	Medicare — Contact information
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Website	www.medicare.gov

Section J Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

If you move or change your mailing address, it's important that you contact Social Security to let them know.

Method	Social Security — Contact information
Call	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Website	www.ssa.gov

Section K Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the RRB, let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

Method	Railroad Retirement Board (RRB) — Contact information
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press "1" to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number aren't free.
Website	www.rrb.gov

Chapter 3

Using the plan's coverage for your health care and other covered services

Chapter 3

Using the plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your Care Manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you're billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

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Section A Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this **Member Handbook**. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this **Member Handbook**.

Providers are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment as full payment. We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

Section B Rules for getting services our plan covers

Our plan covers all services covered by Medicare and MassHealth (Medicaid). This includes behavioral health, LTSS, and prescription and over-the-counter (OTC) drugs.

Our plan will pay for health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this **Member Handbook**.
- The care must be **medically necessary**. By medically necessary, we mean that the services are reasonable and necessary:
  - For the diagnoses and treatment of your illness or injury; **or**
  - To improve the functioning of a malformed body part; **or**
  - Otherwise medically necessary under Medicare law
- In accordance with Medicaid law and regulation and per MassHealth (Medicaid), services are medically necessary if:
  - They could be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger your life, cause you suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; **and**
  - There's no other medical service or place of service that's available, works as well, and is suitable for you that's less expensive. The quality of medically necessary services must meet

professionally recognized standards of health care, and medically necessary services must also be supported by records including evidence of such medical necessity and quality.

- If you have questions about if a service is medically necessary or not, you can contact Member Services.
- For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (for more information, go to **Section D1** of this chapter).
  - In most cases, your network PCP or our plan must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a **Referral**. If you don't get approval, we may not cover the services.
  - You don't need referrals from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, go to **Section D1** in this chapter).
- **You must get your care from network providers** (for more information, go to **Section D** in this chapter). Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, go to **Section I** in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. In this situation, we cover the care at no cost to you. For information about getting approval to use an out-of-network provider, go to **Section D4** in this chapter.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible.

Section C Your Care Manager

Section C1 What a Care Manager is

A Care Manager is a trained person who works for our plan to provide care coordination services for you.

Everyone who enrolls in a Senior Care Options (SCO) plan also has the right to have a Geriatric Support Services Coordinator (GSSC) on their care team.

A GSSC will work with you as a member of your SCO plan to find resources and services in your community that can support your wellness, independence, and recovery goals. These services are

sometimes called long-term services and supports (LTSS). GSSCs may also be able to help you access behavioral health resources and services.

GSSCs don't work for SCO plans. They come from Aging Services Access Points (ASAPs) and are experts in areas like independent living, recovery, and aging. This means that they can work for you and help you advocate for your needs.

You can choose to have a GSSC work with you as a full member of your care team at any time. This is a free service for you.

Section C2 How you can contact your Care Manager

Contact your Care Manager by calling Member Services toll-free at **1-888-867-5511** and TTY **711**.

Section C3 How you can change your Care Manager

Contact your Care Manager by calling Member Services toll-free at **1-888-867-5511** and TTY **711**.

Section D Care from providers

Section D1 Care from a primary care provider (PCP)

Definition of a PCP and what a PCP does do for you

- **What is a PCP?**

  A Primary Care Provider (PCP) is a licensed network physician who is selected by you to provide or coordinate your covered services.

- **What types of providers may act as a PCP?**

  PCPs are generally physicians specializing in Internal Medicine, Family Practice or General Practice.

- **What is the role of my PCP?**

  Your relationship with your PCP is an important one because your PCP is responsible for your routine health care needs, for the coordination of all covered services provided to you, for maintaining a central medical record for you, and for ensuring continuity of care. If you need an appointment with a network specialist or other network provider who is not your PCP, you must obtain a referral from your PCP.

Your choice of PCP

Upon enrollment, the Plan will help you choose a PCP. Member Services can assist you in the selection of a new PCP whenever necessary. You must select a PCP in our network when you

complete the enrollment application. If there is a particular specialist or hospital that you want to use, check first to see if they are in our network of providers.

Indian members have the option to choose an Indian Health Care Provider as a Primary Care Provider if we have an Indian Primary Care Provider in our network and s/he has capacity to provide such services. We will permit Indian members to obtain Covered Services from out-of- network Indian Health Care Providers from whom they are otherwise eligible to receive such covered services. We will also permit an out-of-network Indian Health Care Provider to refer an Indian member to a Network Provider.

For a copy of the most recent **Provider Directory**, or for help in selecting a PCP, call Member Services or visit the website listed in Chapter 2 of this booklet for the most up-to-date information about our network providers.

Option to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

If you want to change your PCP, call Member Services or go online. If the PCP is accepting additional plan members, the change will become effective on the first day of the following month. You may receive a new UCard that shows this change.

Transition of Care

New members can continue to obtain current services for the first 90 days of their enrollment, using their existing provider. During this time, UHC Senior Care Options (HMO D-SNP) works with you to make sure that the services you are getting continue to be medically necessary. Also, if your current provider is not within the Network, we will help to determine if that provider can become participating or help to transition you to an in-network provider.

Services you can get without approval from your PCP

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers.
- Urgently needed covered services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.

- Flu shots and COVID-19 vaccines, as well as hepatitis B vaccines and pneumonia vaccines as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.
- Services from the following types of physician specialists: Obstetrics/Gynecology (OB/GYN), Hematologist, Oncologist, Neonatologist, Emergency Medicine, Hospitalist, Infectious Disease, Nuclear Medicine, Radiologist, or Therapeutic Radiology provider.

If you're not sure if you need a referral to get a service or use another provider, ask your Care Manager, PCP, or call Member Services at the number at the bottom of this page.

Section D2 Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.
- Neither the plan nor Medicare will pay for services, supplies, treatments, surgeries, and/or drug therapies for which a referral is required, but was not obtained from your PCP or us, except for emergency services, urgently needed services, out-of-area dialysis and post-stabilization care services, or when you have a prior authorization for an out-of-network provider.
- When you select a PCP it is important to remember that your PCP will choose the network specialist to whom you will be referred based upon his or her referring practices and hospital affiliation. The presence of a particular network specialist in this directory does not mean that your PCP will refer you to that provider.

Please refer to the **Provider Directory** for a listing of Plan specialists available through your network, or you may consult the **Provider Directory** online at **myuhc.com/CommunityPlan**.

Section D3 When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have these rights and protections that are summarized below:

- Even if our network of providers changes during the year, we must give you uninterrupted access to qualified providers.

- We'll notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past three years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

Section D4 Out-of-network providers

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or MassHealth (Medicaid).

- We can't pay a provider who isn't eligible to participate in Medicare and/or MassHealth (Medicaid).
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.

Section E Long-term services and supports (LTSS)

UHC Senior Care Options covers services covered by Medicare and MassHealth (Medicaid). This includes behavioral health, long-term services and supports (LTSS), and prescription and over the counter (OTC) drugs.

UHC Senior Care Options will pay for the health care and services you get if you follow the plan rules listed below. To be covered by our plan:

- The care you get must be a **plan benefit**. This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4, Section D of this handbook).
- The care must be **medically necessary**. Medically necessary means that the services are reasonable and necessary:
  - For the diagnosis and treatment of your illness or injury; **or**
  - To improve the functioning of a malformed body part; **or**
  - Otherwise medically necessary under Medicare law
  - In accordance with Medicaid law and regulation and per MassHealth (Medicaid), services are medically necessary if:
- They could be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger your life, cause you suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; **and**
- There is no other medical service or place of service that is available, works as well, and is suitable for you that is less expensive. The quality of medically necessary services must meet professionally recognized standards of health care, and medically necessary services must also be supported by records including evidence of such medical necessity and quality.

If you have questions about if a service is medically necessary or not, you can contact the Member Services at **1-866-867-5511** (TTY **711**), 8 a.m.–8 p.m. local time, 7 days a week. The call is free.

- You must have a **primary care provider (PCP)** that is in our plan network (a network PCP). As a plan member, you must choose a network provider to be your PCP.
  - To learn more about choosing a PCP, refer to Section D.
  - In most cases, your network PCP or our plan must give you authorization or approval before you can use someone that is not your PCP or use other providers in the plan's network or receive certain services. This is called a **Referral**. If you or your Provider doesn't get an authorization ahead of time, **UHC Senior Care Options** may not cover the services. You don't need an authorization to use certain specialists, such as women's health specialists. For

more information about services that require an authorization, refer to the Benefits Charts in Chapter 4.

- You do not need prior authorization from your PCP for emergency care or urgently needed care. You can also get other kinds of care without having a referral from your PCP.
- **Note:** In your first 90 days with our plan or until your Individualized Care Plan (ICP) is complete, you can keep going to your current providers, at no cost to you, if they are not a part of our network. This is called the Continuity of Care (COC) period. During the COC period, our Care Manager will contact you to help you find providers in our network. After the COC period, we will no longer cover your care if you choose to use out-of-network providers.

- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the health plan. But sometimes this rule does not apply, for example:
  - The plan covers emergency or urgently needed care from an out-of-network provider.
  - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. You will need to talk to your Care Manager prior to seeking care. A prior authorization will be needed. In this situation, we will cover the care at no cost to you. To learn about getting approval to use an out-of-network provider, call your Care Manager or Member Services..
  - The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility.
  - When you first join the plan, you can continue going to the providers you see use now for the Continuity of Care (COC) period.

Section F Behavioral health (mental health and substance use disorder) services

Behavioral health services, including mental health and alcohol and substance abuse disorder services, are covered by the plan. You do not need a referral from your PCP to see a behavioral/ mental health provider.

If you need behavioral health services, including immediate access to our Behavioral HealthCrisis Line:

Call **1-888-867-5511**, TTY **711**. Calls to this number are free. 24 hours a day, 7 days a week.

Section G How to get self-directed care

Your UHC Senior Care Options Care Manager can help you connect with behavioral health services in your area. You can also use our online Find a Doctor, Hospital or Pharmacy tool to locate network providers in your area or call the Member Services at the number listed at the bottom of this page.

Section G1 What self-directed care is

Self-directed care recognizes that the individual is knowledgeable about his or her own care needs, and the individual is empowered and accountable for his or her own care; and places an emphasis on environmental change and quality of life. Self-directed care emphasizes the ability of you, as a consumer, to:

- Advocate for your own needs
- To make choices about what services would best meet those needs
- To monitor the quality of those services

The self-directed model for personal care services is called the Personal Care Attendant (PCA) program. In this model, personal care attendants are recruited, hired, trained, supervised, and, if necessary, fired by the consumer. You do not have to worry about paying the bills yourself in this model. UHC Senior Care Options will do that on your behalf.

Section G2 Who can get self-directed care

If you meet the functional and clinical eligibility for personal care services, you may choose to self-direct these services through the Personal Care Attendant (PCA) program. The amount of services you are eligible for will be approved by your Care Team and will be based upon standards that are consistent with the criteria set by MassHealth (Medicaid) regulations. Support and skills training are provided by Personal Care Management agencies, under contract with UHC Senior Care Options, to provide information to members about what is involved in self-direction, and to obtain any skills necessary to manage their own services, including the recruitment, hiring, training, supervision and firing of personal care attendants. UHC Senior Care Options will work with the "fiscal intermediary" to pay the bills for these services under the plan. In self-directed care, you do not have to take care of the payment yourself.

Section G3 How to get help in employing personal care providers (if applicable)

You can ask your Care Manager to help you access resources to employ personal care attendants.

They will connect you with a Personal Care Management agency that can provide skills training to assist with employment functions. The Personal Care Management agency will work with you to develop the skills necessary to oversee the employment of personal care attendants and engage in collaborative problem-solving.

Section G4 How to request that a copy of all written notices be sent to Care Team participants the member identifies

To request a copy of all written notices, please contact your Care Manager or call Member Services at the number listed at the bottom of this page.

Section H Transportation services

You have access to emergency and non-emergent transportation. If you need an ambulance to get to the emergency room, our plan covers that. Ground or air ambulance services that you may need in a medical emergency are covered. In specific circumstances, we may also cover nonemergency medical transportation if you have a written order from your doctor stating that the transportation is medically necessary. For example, someone with End-Stage Renal Disease may need medically necessary ambulance transport to a kidney dialysis facility. Non-emergency transportation is arranged through your enrollee services transportation SafeRide. Covered nonemergent transportation services include mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage). You can also ask your PCP or Care Manager to help you to arrange this service. Please call us toll-free at **1-888-867-5511**, TTY **711** to help arrange transportation. Available, 8 a.m.–8 p.m. local time, 7 days a week. We have free interpreter services for people who do not speak English.

Section I Dental and Vision services

Dental Services

Our plan provides access to dental benefits that includes preventive, restorative, and emergency oral health care. Your coverage includes up to two cleanings per calendar year.

You must go to a participating dental provider for all covered dental services.

Some services may require a prior authorization by UHC Senior Care Options (HMO D-SNP).

Your dentist will need to submit a prior authorization directly to UnitedHealthcare Dental, our dental benefit administrator.

Vision Services

The plan covers professional care of the eyes for purposes of preventing, diagnosing and treating all pathological conditions. They include eye examinations, prescriptions, glasses and contact lenses.

Prior authorization is not required for outpatient vision services provided by a contracted provider. Limitations and authorization requirements for frames may apply. Please see Benefits Charts in Chapter 4 for more information on covered vision care and limitations that may apply.

Section J Covered services in a medical emergency, when urgently needed, or during a disaster

Section J1 Care in a medical emergency

A medical emergency is a medical condition with symptoms such as illness, severe pain, serious injury, or a medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your life; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, tell our plan about your emergency.** We follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. You can call the number on the back of your Ucard.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of this **Member Handbook**.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They'll continue to treat you and will contact us to make plans if you need follow-up care to get better.

When you receive emergency care in the United States, after the emergency is over you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

When you receive emergency care outside of the United States under the worldwide emergency benefit, only the medical services directly related to the immediate medical emergency are covered while you remain in a foreign country. Follow-up care received outside of the United States after your condition has been stabilized is generally not covered, even if the care is related to the original emergency. Coverage is limited to emergency services required to stabilize your condition. Any care received beyond stabilization must occur within the United States to be eligible for coverage.

What to do if you have a behavioral health emergency

In a behavioral health emergency, you should go to the nearest emergency room. You will be evaluated by a crisis team that will assist in finding you an appropriate facility for care. No prior authorization is required for this type of emergency within the U.S. and its territories.

You can also contact the Massachusetts Emergency Services Program (ESP) at **833-773-2445** and www.masshelpline.com. ESP provides behavioral health crisis assessment, intervention, and stabilization services, 24 hours a day, seven days per week, and 365 days a year. ESP includes three services:

1. Mobile Crisis Intervention (MCI) services for adults — these services are available 24 hours a day, seven days a week, as follows: from 7 a.m. to 8 p.m. at all ESP community-based locations, and from 8 p.m. to 7 a.m. at residential programs and hospital emergency departments.
2. Emergency Services Program (ESP) community-based locations — hours vary based on location. For details, go to **masspartnership.com/pdf/MBHPESPDirectory.pdf**.
3. Community crisis stabilization (CCS) services for people age 18 and older — these services are available 24 hours a day, seven days a week. For details, go to **masspartnership.com/pdf/MBHPESPDirectory.pdf**.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

However, after the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

Section J2 Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it isn't possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care you get from an out-of-network provider.

Check your **Provider Directory** for a list of network Urgent Care Centers.

Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Our plan covers worldwide emergency and urgently needed services outside the United States under the following circumstances: emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. Transportation back to the United States from another country is not covered, regardless of whether that transportation is via ambulance or some other method of transportation. Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition) and/ or elective procedures are not covered.

Section J3 Care during a disaster

If the governor of Massachusetts, the U.S. Secretary of Health and Human Services, or the president of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit our website for information on how to get care you need during a declared disaster: **uhc.com/disaster-relief-info**.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this **Member Handbook** for more information.

Section K What if you're billed directly for covered services

If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of this **Member Handbook** to find out what to do.

You shouldn't pay the bill yourself. If you do, we may not be able to pay you back.

Section K1 What to do if our plan doesn't cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of this **Member Handbook**), **and**
- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself**.

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we won't pay for your services, you have the right to appeal our decision.

Chapter 9 of this **Member Handbook** explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

Section L Coverage of health care services in a clinical research study

Section L1 Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with

evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your Care Manager to contact Member Services to let us know you'll take part in a clinical trial.

Section L2 Payment for services when you're in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- an operation or other medical procedure that's part of the research study
- treatment of any side effects and complications of the new care

If you volunteer for a clinical research study, we pay any costs that Medicare doesn't approve but that our plan approves. If you're part of a study that Medicare or our plan **hasn't** approved, you pay any costs for being in the study.

Section L3 More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf).You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section M How your health care services are covered in a religious non-medical health care institution

Section M1 Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

Section M2 Care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're against getting medical treatment that's "non-excepted."

- "Non-excepted" medical treatment is any care or treatment that's **voluntary and not required** by any federal, state, or local law.
- "Excepted" medical treatment is any care or treatment that's **not voluntary and is required** under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from us before you're admitted to the facility, or your stay won't be covered.

Medicare Inpatient Hospital coverage limits apply. The coverage limits are described under **Inpatient Hospital Care** in the Medical Benefits Chart in Chapter 4.

Section N Durable medical equipment (DME)

Section N1 DME as a member of our plan

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you usually **won't** own the rented DME items, no matter how long you rent it.

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you **won't** own the equipment.

Section N2 DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

You'll have to make 13 payments in a row under Original Medicare, or you'll have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you didn't become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan**.

- You'll have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan

Section N3 Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

Section N4 Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment, and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to 5 years if medically necessary

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4

Benefits chart

Chapter 4

Benefits chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services and how much you pay for each service. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

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Section A Your covered services

This chapter tells you about services our plan covers. You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of this **Member Handbook**. This chapter also explains limits on some services.

Because you get help from MassHealth (Medicaid), you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of this **Member Handbook** for details about our plan's rules.

If you need help understanding what services are covered, call your Care Manager and/or Member Services at **1-888-867-5511**, TTY **711**, 8 a.m.–8 p.m. local time, 7 days a week.

Section B Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of this **Member Handbook** or call Member Services.

Section C About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met. You don't pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and MassHealth (Medicaid) covered services according to the rules set by Medicare and MassHealth (Medicaid).
- The services must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.

- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed care, or unless your plan or a network provider gave you a referral. **Chapter 3** of this **Member Handbook** has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a referral. **Chapter 3** of this **Member Handbook** has more information about getting a referral and when you **don't** need one.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA italic type.
- If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.
- If you are within our plan's 60 day period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, your MassHealth (Medicaid) coverage may end sooner than your Medicare coverage with us. When your MassHealth (Medicaid) coverage ends, we will not pay for your MassHealth (Medicaid) benefits including the Medicare cost sharing. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.

We will assist your efforts to regain your (MassHealth) Medicaid eligibility. If your MassHealth (Medicaid) eligibility is restored while you are still enrolled with us for your Medicare coverage, we will resume paying for your MassHealth (Medicaid) benefits and your enrollment with us will continue. If you regain MassHealth (Medicaid) eligibility after we disenroll you from our Medicare coverage you will need to reach out to reenroll with us.

This apple shows the preventive services in the Benefits Chart.

Section D Our plan's Benefits Chart

Services that our plan pays for	What you must pay
Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0

Services that our plan pays for	What you must pay
Acupuncture We pay for acupuncture services: • To treat pain; • As part of SUD treatment; and • for related evaluation and treatment planning office visits. We require prior approval after 20 acupuncture treatments in each year for pain or SUD treatment. Your provider may also change or stop your treatment plan if you're not getting better after the first 4 treatments.For chronic low back pain, we pay for up to 12 acupuncture visits in 90 days. Chronic low back pain is defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, • inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. We will also pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement in the first 12 visits. Acupuncture treatments must be stopped if you don't get better or if you get worse. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization.* Referral may be required

Services that our plan pays for	What you must pay
Acupuncture (continued) • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. Acupuncture services performed by providers that do not meet CMS acupuncture provider requirements are not covered even in locations where there are no providers available that meet CMS requirements.	
Adult day health services The plan covers services from adult day health providers at an organized program. These services may include the following: • nursing services and health oversight • therapy • assistance with activities of daily living • nutritional and dietary services • counseling services • activities • case management • transportation	$0 *You must obtain prior authorization from your Health Plan.*
Adult foster care services The plan covers services from adult foster care providers in a residential setting. These services may include the following: • assistance with activities of daily living, instrumental activities of daily living, and personal care • supervision • nursing oversight	$0 *Your provider may need to obtain prior authorization.*

Services that our plan pays for	What you must pay
Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	$0
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Outside of the United States, our worldwide emergency benefit covers emergency ambulance transportation only from the scene of an emergency to the nearest medical treatment facility within the foreign country. Transportation back to the United States from another country is not covered, regardless of whether that transportation is via ambulance or some other method of transportation. Generally, you will pay the full cost of any emergency ambulance services received outside of the United States at the time you receive the services and then you will need to request reimbursement from us. Payment requests that we receive from intermediaries, claims management companies or third-party billers for services that you received outside of the United States are not reimbursable.	$0 *Your provider may need to obtain prior authorization for non-emergency transportation*

Services that our plan pays for	What you must pay
Annual routine physical exam Includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. Annual Routine Physical Exam visits do not need to be scheduled 12 months apart but are limited to one visit each calendar year.	$0 for a routine physical exam each year.
Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Welcome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	$0
Audiologist services The plan covers audiologist (hearing) exams and evaluations.	$0 *Your provider may need to obtain prior authorization.*
Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0
Breast cancer screening (mammograms) We pay for the following services: • one screening mammogram every 12 months • clinical breast exams once every 24 months	$0

Services that our plan pays for	What you must pay
Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's referral. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0 *Your provider may need to obtain prior authorization for some services.*
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you're eating well.	$0
Cardiovascular (heart) disease testing We pay for blood tests to check for cardiovascular disease once every 5 years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0
Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months	$0

Services that our plan pays for	What you must pay
Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment • Manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position). Manual manipulation is a treatment that uses hands-on pressure to gently move your joints and tissues. Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation, including: • Maintenance therapy. Chiropractic treatment is considered maintenance therapy when continuous ongoing care is no longer expected to provide clinical improvements and the treatment becomes supportive instead of corrective. • Extra charges when your chiropractor uses a manual, handheld device to add controlled pressure during treatment. • X-rays, massage therapy, and acupuncture (unless the acupuncture is for the treatment of chronic low back pain).	$0 *Your provider may need to obtain prior authorization for some services.*
Chronic care management services, including chronic pain management and treatment plan services If you have serious chronic conditions and receive chronic care management services, your provider develops a monthly comprehensive care plan that lists your health problems and goals, providers, medications, community services you have and need, and other information about your health. Your provider also helps coordinate your care when you go from one health care setting to another.	$0 *Your provider may need to obtain prior authorization for some services.* Referral may be required.

Services that our plan pays for	What you must pay
Colorectal cancer screening The plan will pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 65 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonsocopy was performed. • Flexible sigmoidoscopy for patients 65 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy. • Screening fecal-occult blood tests for patients 65 years and older. Once every 12 months. • Multitarget stool DNA for patients 65 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 65 to 85 years of age and not meeting high risk criteria. Once every 3 years. **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Colorectal cancer screening (continued) • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered noninvasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test. • Outpatient diagnostic colonoscopy	
Community health center services The plan covers services from a community health center. Examples include the following: • office visits for primary care provider and specialists • OB/GYN • pediatric services, including EPSDT • health education • medical social services • nutrition services, including diabetes self-management training and medical nutrition therapy • tobacco-cessation services • vaccines not covered by the Massachusetts Department of Public Health (MDPH)	$0
Companion services Includes socialization, help with shopping and errands, escort to doctor's appointments, nutrition sites, walks, recreational activities, and assistance with preparation and serving of light snacks.	

Services that our plan pays for	What you must pay
Day habilitation services The plan covers a program of services offered by day habilitation providers if you qualify because you have an intellectual or developmental disability. At this program, you develop a service plan that includes your goals and objectives and the activities to help you meet them. These services may include the following: • nursing services and health care supervision • developmental-skills training • therapy services • life skills/adult daily living training	$0 *Your provider may need to obtain prior authorization for some services.*
Dental services The plan covers preventative, restorative, and emergency oral health care. We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.	$0 *Your provider may need to obtain prior authorization for some services.*
Routine dental benefits You can get more information about this benefit by viewing the Vendor Information Sheet at **myUHC.com/CommunityPlan** or by calling Member Services to have a paper copy sent to you.	You are covered for routine dental benefits. See the routine dental benefits description at the end of this chart for details. *Your provider may need to obtain prior authorization for some services.*
Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	$0

Services that our plan pays for	What you must pay
Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	$0

Services that our plan pays for	What you must pay
Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not). **Covered services include:** • Supplies to monitor your blood glucose: continuous glucose monitors (CGMs), blood glucose monitors (BGMs), blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • You can get certain CGMs from your pharmacy, and all are available from a DME provider at the same cost. If you have Type 1 diabetes, you don't need prior authorization. For Type 2 diabetes and other conditions, you will need a prior authorization for CGMs from a DME provider. Prior authorizations for CGMs and supplies are approved for 12 months. Or you can get certain CGMs from a pharmacy without prior authorization if your claim history includes insulin or any type of CGM device part (ex. sensors, transmitters). • For details on Medicare's CGM requirements, visit medicare.gov/coverage/therapeutic-continuousglucose-monitors • We cover the blood glucose monitors and test strips in this list. We don't usually cover other brands unless your provider tells us it's medically necessary. If you're new to the plan and using a brand that isn't on our list, you can request a temporary supply within the first 90 days of enrollment while you talk with your provider. They can help you decide if any of the preferred brands work for you. If you or your provider think it's medically necessary for you to keep using a different brand, you can request a coverage exception to have it covered for the rest of the plan year. After the first 90 days of enrollment, non-preferred products will only be covered with an approved exception. • For people with diabetes who have severe diabetic foot disease, we pay for the following: – one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** **This benefit is continued on the next page**	$0 for each Medicare-covered continuous glucose monitor (CGM) and supplies with an approved prior authorization. There are no brand limitations for CGMs. $0 for each Medicare-covered blood glucose monitor (BGM). For BGMs, we only cover Contour® and Accu-Chek® brands. Other brands are not covered by our plan. Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide. Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus.

Services that our plan pays for	What you must pay
Diabetic self-management training, services, and supplies (continued) – one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.	
Durable Medical Equipment (DME) and related supplies Refer to **Chapter 12** of this **Member Handbook** for a definition of "Durable Medical Equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. We pay for all medically necessary DME that Medicare and MassHealth (Medicaid) usually pay for. If our supplier in your area doesn't carry a particular brand or maker, you may ask them if they can special order it for you.	$0 copayment for Medicarecovered benefits. Your cost sharing for Medicare oxygen equipment coverage is $0 copayment, every time you get covered equipment or supplies. Your cost sharing won't change after you're enrolled for 36 months. If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in our plan, your cost sharing in our plan is $0 copayment. *Your provider may need to obtain authorization for some services.*

Services that our plan pays for	What you must pay
Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to evaluate or treat a medical emergency. A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your life; **or** • serious harm to bodily functions; **or** • loss of a limb, or loss of function of a limb. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. As a SCO member, your cost sharing is $0. Worldwide coverage for emergency department services outside of the United States. • This includes emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. • Transportation back to the United States from another country is not covered, regardless of whether that transportation is via ambulance or some other method of transportation. • Any pre-scheduled services, scheduled appointments, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures are not covered outside of the United States, even if those services are related to a previous emergency. • Services provided by a dentist are not covered. • Provider access fees, appointment fees and administrative fees are not covered. **This benefit is continued on the next page**	Within the United States: $0 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you are admitted to a hospital, you will pay cost-sharing as described in the "Inpatient hospital care" section in this benefit chart. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital.

Services that our plan pays for	What you must pay
Emergency care (continued) • Generally, you will pay the full cost of emergency services received outside of the United States at the time you receive services and then will request reimbursement from us. Payment requests we receive from intermediaries, claims management companies or third-party billers for services received outside of the United States are not reimbursable.	Outside the United States: $0 copayment for worldwide coverage for emergency services outside of the United States. In most cases you will pre-pay the foreign provider for the service and request reimbursement. Please see Chapter 7 for expense reimbursement for worldwide emergency services.
Fitness program Your fitness program helps you stay active and connected at the gym, from home or in your community. It's available to you at no cost and includes: • Free gym membership at core and premium locations • Access to a large national network of gyms and fitness locations • On-demand workout videos and live streaming fitness classes • Online memory fitness activities See **Chapter 11** for the fitness program terms and conditions of coverage. You can get more information by viewing the Vendor Information Sheet at **myUHC.com/CommunityPlan** or by calling Member Services to have a paper copy sent to you.	$0 A home-delivered fitness kit is available if you live 15 miles or more from a network gym or fitness location. Coverage is limited to in-network locations only.

Services that our plan pays for	What you must pay
Group adult foster care The plan covers services provided by group adult foster care providers for members who qualify. These services are offered in a group-supported housing environment and may include the following: • assistance with activities of daily living, instrumental activities of daily living, and personal care • supervision • nursing oversight • care management	$0
Health and wellness education programs The plan covers all health and wellness education programs covered by Medicare and MassHealth (Medicaid). Covered services include but are not limited to: • smoking and tobacco use cessation (see also "Counseling to stop smoking or tobacco use" earlier in this section) • access to 24/7 Nurse Advice Call Line (see Chapter 2, Section C for more information on accessing Nurse Advice Call Line) • health education (see "Community health center services" earlier in this section) • nutrition education (see also "Community health center services" earlier in this section and "Medical nutrition therapy" later in this section for more information on covered services) • diabetes self-management-training and education (see also "Diabetes self-management training services and supplies" earlier in this section for more information) • kidney disease education services to teach kidney care and help members make informed decision about their care (see also "Renal (Kidney) disease services and supplies" later in this section for more information)	$0 *Prior authorization may be required. Please contact your Care Coordinator.*

Services that our plan pays for	What you must pay
Hearing services, including hearing aids We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. The plan also covers the following: • providing and dispensing hearing aids, batteries, and accessories • instruction in the use, care, and management of hearing aids • ear molds • ear impressions • loan of a hearing aid, when necessary **Routine hearing exam** We cover 1 hearing exam every year.	$0 *Your provider may need to obtain prior authorization for some services.* Referral may be required.
HIV screening We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. If you're pregnant, we pay for up to three HIV screening tests during a pregnancy.	$0

Services that our plan pays for	What you must pay
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies	$0 *Your provider may need to obtain prior authorization for some services.*
Home health aide services The plan covers services from a home health aide, under the supervision of a licensed RN or other professional, for members who qualify. Services may include the following: • simple dressing changes • assistance with medications • activities to support skilled therapies • routine care of prosthetic and orthotic devices	$0 *Your provider may need to obtain prior authorization for some services.*

Services that our plan pays for	What you must pay
Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but aren't limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	$0 *Your provider may need to obtain prior authorization for some services*. Referral may be required.
Homeless medical respite services You have access to pre- and post-colonoscopy support to prepare for and recover after a colonoscopy procedure. You have access to recovery support post acute medical issues, case management and health and referral navigation to address other health and social needs, and planning support for transition to settings in the community.	$0

Services that our plan pays for	What you must pay
Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care • If you choose to get your hospice care in a nursing facility, UHC Senior Care Options (HMO D-SNP) will cover the cost of room and board. **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Hospice care (continued) **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of this **Member Handbook**. **Note:** If you need non-hospice care, call your Care Manager and/or member services to arrange the services. Non-hospice care is care that **isn't** related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill member who hasn't chosen the hospice benefit.	
Immunizations We pay for the following services: • pneumonia vaccines • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you're at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you're at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this **Member Handbook** to learn more.	$0
Independent nursing The plan covers care from a nurse in your home. The nurse may either work for a home health agency or may be an independent nurse.	$0

Services that our plan pays for	What you must pay
Inpatient behavioral health care Inpatient services, such as: • inpatient mental health services to evaluate and treat an acute psychiatric condition • inpatient substance use disorder services • observation/holding beds • administratively necessary day services Under this plan, there's no lifetime limit on the number of days a member can have in an inpatient behavioral health care facility.	$0 *Your provider may need to obtain prior authorization for some services.*

Services that our plan pays for	What you must pay
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. **This benefit is continued on the next page**	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized. *Your provider may need to obtain prior authorization for some services.*

Services that our plan pays for	What you must pay
Inpatient hospital care (continued) If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. The plan has a network of facilities that perform organ transplants. The plan's hospital network for organ transplant services is different than the network shown in the "Hospitals" section of your provider directory. Some hospitals in the plan's network for other medical services are not in the plan's network for transplant services. For information on network facilities for transplant services, contact Member Services. • blood, including storage and administration • physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet **Medicare Hospital Benefits**. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. Covered services include: • Behavioral health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient behavioral health services provided in a psychiatric unit of a general hospital. • Inpatient substance use disorder services	$0 *Your provider must obtain prior authorization.*

Services that our plan pays for	What you must pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We pay for the following services while you are in the hospital or a nursing facility, and maybe other services not listed here: • doctor services • diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • surgical dressings • splints, casts, and other devices used for fractures and dislocations • prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: – an internal body organ (including contiguous tissue), **or** – the function of an inoperative or malfunctioning internal body organ. • leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition • physical therapy, speech therapy, and occupational therapy	

Services that our plan pays for	What you must pay
Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this **Member Handbook**, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B pays for some drugs for dialysis. For information, refer to "Medicare Part B drugs" in this chart.	$0 *Your provider may need to obtain prior authorization for some services.*

Services that our plan pays for	What you must pay
Lung cancer screening with low dose computed tomography (LDCT) Our plan pays for lung cancer screening every 12 months if you: • are aged 50–77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits. **For LDCT lung cancer screenings after the initial LDCT screening:** the member must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	$0
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when ordered by your doctor. We pay for 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for 2 hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	$0

Services that our plan pays for	What you must pay
Medically necessary non-emergency transportation The plan covers transportation you need for medical reasons other than emergencies.	$0 *Your provider may need to obtain prior authorization for non-emergency transportation.*
Medicare Diabetes Prevention Program (MDPP) Our plan pays for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0

Services that our plan pays for	What you must pay
Medicare Part B drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • the Alzheimer's drug Leqembi® (generic lecanemab) which is given intravenously (IV) • clotting factors you give yourself by injection if you have hemophilia • transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself • some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does **This benefit is continued on the next page**	$0 Your provider may need to obtain prior authorization for some services.

Services that our plan pays for	What you must pay
Medicare Part B drugs (continued) • oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • calcimimetic and phoshate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics • erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epotin beta) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) • Chemotherapy Drugs, and the administration of chemotherapy drugs We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **Chapter 5** of this **Member Handbook** explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this **Member Handbook** explains what you pay for your drugs through our plan.	

Services that our plan pays for	What you must pay
Nursing facility care A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Services that we pay for include, but aren't limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • blood, including storage and administration • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Nursing facility care (continued) You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0
Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0 *Your provider may need to obtain prior authorization for some services/drugs.*
Orthotic services The plan covers braces (non-dental) and other mechanical or molded devices to support or correct the form or function of the human body.	$0 *Your provider may need to obtain prior authorization for some services.*

Services that our plan pays for	What you must pay
Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition • other outpatient diagnostic tests – Non-radiological diagnostic services – Radiological diagnostic services, not including x-rays	$0 *Your provider may need to obtain prior authorization for some services.*
Outpatient drugs Please read **Chapter 5** for information on drug benefits, and **Chapter 6** for information on what you pay for drugs.	$0

Services that our plan pays for	What you must pay
Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an **inpatient or can be discharged**. The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: **Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff.** Get more information in the Medicare fact sheet **Medicare Hospital Benefits**. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf HYPERLINK "https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf"	$0

Services that our plan pays for	What you must pay
Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services – Observation services help your doctor know if you need to be admitted to the hospital as "inpatient." – Sometimes you can be in the hospital overnight and still be "outpatient." – You can get more information about being inpatient or outpatient in this fact sheet: es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf. • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself • Outpatient infusion therapy **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and paynthe cost-sharing amounts for outpatient hospital services. As a SCO member, your cost sharing is $0. Even if you stay in the hospital overnight, you might still be considered an outpatient. This is called an Outpatient Observation stay. If you are not sure if you are an outpatient, you should ask the hospital staff. **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services.*

Services that our plan pays for	What you must pay
Outpatient hospital services (continued) You can also find more information in a Medicare fact sheet called **Are You a Hospital Inpatient or Outpatient? If You Have Medicare—Ask!** This fact sheet is available on the Web at **es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws The plan covers services including: • individual, group, and couples/family treatment • medication visit • diagnostic evaluation • family consultation • case consultation • psychiatric consultation on an inpatient medical unit • inpatient-outpatient bridge visit • acupuncture treatment • opioid replacement therapy **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services.*

Services that our plan pays for	What you must pay
Outpatient mental health care (continued) • ambulatory detoxification (Level II.d) • psychological testing • Dialectrical Behavioral Therapy • Emergency Department-based Crisis Intervention Mental Health Services • Electro-Convulsive Therapy • Repetitive Transcranial Magnetic Stimulation (rTMS) • Specialing	
Outpatient rehabilitation and therapy services We pay for physical therapy, occupational therapy, and speech therapy, and related comprehensive evaluations. You can get outpatient rehabilitation and therapy services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0 *Your provider may need to obtain prior authorization for some services.* Referral is required.
Outpatient substance use disorder services We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment	$0 *Your provider may need to obtain prior authorization for some services.*
Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Note:** Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient.	$0 *Your provider may need to obtain prior authorization for some services.*

Services that our plan pays for	What you must pay
Over-the-counter (OTC) credit With this benefit, you'll get a credit loaded to your UCard each month to buy covered OTC items. Unused credit expires at the end of each month. Covered items include brand name and generic OTC products like vitamins, pain relievers, bladder control pads and first aid products. The credit cannot be used to buy tobacco or alcohol.	Monthly credit is $125
Home and bath safety devices You can also use your OTC credit on covered home and bath safety devices like bathmats, grab bars and shower chairs.	
Fitness equipment You can use your OTC credit on covered fitness equipment like fitness mats, exercise machines or handheld weights, and wearable devices or activity trackers.	Combined with OTC credit amount
Support services You can also use your OTC credit on covered in-home support services such as respite care, non-skilled in-home care, and weight management services.	Combined with OTC credit amount
Healthy food — Special Supplemental Benefits for the Chronically Ill (SSBCI) If you qualify, a healthy food and utilities credit will be included as part of your OTC credit expiring monthly. Your eligibility for the healthy food credit is determined after you enroll in this plan You must have at least one of the following chronic conditions to qualify: • Diabetes mellitus (type 1 or type 2) • Cardiovascular disorders • Chronic heart failure • Chronic hypertension (chronic high blood pressure) • Chronic hyperlipidemia (chronic high cholesterol) • Autoimmune disorders • Cancer **This benefit is continued on the next page**	Combined with OTC credit amount Home shipped food, OTC products, home and bath safety devices and fitness equipment are available nationwide.

Services that our plan pays for	What you must pay
Over-the-counter (OTC) credit (continued) • Chronic alcohol use disorder and other substance use disorders (SUDs) • Chronic gastrointestinal disease • Chronic kidney disease (CKD) • Chronic lung disorders • Chronic and disabling mental health conditions • Dementia • HIV/AIDS • Immunodeficiency and immunosuppressive disorders • Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy • Neurologic disorders • Overweight, obesity and metabolic syndrome • Post-organ transplantation care • Severe hematologic disorders • Stroke • Conditions associated with cognitive impairment • Conditions with functional challenges and require similar services Covered items include: • Healthy foods like fruits, vegetables, meat, seafood, dairy products, water and more. • Eligible utility bills like electricity, home heat like natural gas, water and home internet. The service address must match an address we have on file for you. You can use your credit at thousands of participating stores or place an order online. Home shipping is free and there is a $35 minimum to place an order. Taxes may apply Visit the UCard Hub at **myUHC.com/CommunityPlan** to find participating stores, check your balance or place an order online.	

Services that our plan pays for	What you must pay
Oxygen and respiratory therapy equipment The plan covers services including oxygen systems, refills, and oxygen therapy equipment rental.	$0
Partial hospitalization services and intensive outpatient services **Partial hospitalization** is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization.	$0 *Your provider may need to obtain prior authorization for some services.*

Services that our plan pays for	What you must pay
Personal care attendant services The plan covers personal care attendant services to assist you with activities of daily living and instrumental activities of daily living if you qualify. These include, for example: • bathing • meal preparation and eating • dressing and grooming • medication management • moving from place to place • toileting • transferring • laundry • housekeeping You can hire a worker yourself to help you with hands-on tasks. The plan may also pay for a worker to help you with other tasks, that don't need hands-on help. Your Care Team will work with you to decide if that service is right for you and will be in your Individualized Care Plan (ICP).	$0 *Your provider may need to obtain prior authorization.*
Personal emergency response system With a personal emergency response system (PERS), help is only a button press away. A PERS device can quickly connect you to the help you need, 24 hours a day in any situation. It's a lightweight, discreet button that can be worn on your wrist or as a pendant. It's also safe to wear in the shower or bath. Depending on the model you choose, it may even automatically detect falls. You must have a working landline or live in an area that has appropriate wireless coverage to get a PERS device. The cellular device works nationwide with the wireless network but does not require you to have a contract with the network. You can get more information by viewing the Vendor Information Sheet at (**myuhc.com/CommunityPlan**) or by calling Member Services to have a paper copy sent to you.	$0 A home-delivered device is available nationwide

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits We pay for the following services: • medically necessary health care or surgery services given in places such as: – physician's office – certified ambulatory surgical center – hospital outpatient department • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your specialist, if your doctor orders them to find out whether you need treatment • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder • telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: – You have an in-person visit within 6 months prior to your first telehealth visit – You have an in-person visit every 12 months while receiving these telehealth services – Exceptions can be made to the above for certain circumstances • telehealth services for mental health visits provided by rural health clinics and federally qualified health centers. **This benefit is continued on the next page**	$0 *Your provider must follow prior authorization requirements.* Referral may be required.

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) • virtual check-ins (for example, by phone or video chat) with your doctor for 5–10 minutes **if** – you're not a new patient **and** – the check-in isn't related to an office visit in the past 7 days **and** – the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: – you're not a new patient **and** – the evaluation isn't related to an office visit in the past 7 days **and** – the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery • Our plan covers certain telehealth services beyond Original Medicare, including: – Additional virtual medical visits: • Urgently needed services • Primary care provider • Specialist • Other non-physician health care professional or a nurse practitioner **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) – Additional virtual visits for individual mental health therapy sessions: • Outpatient mental health care • Outpatient substance use disorder services • You can access your virtual mental health visits even if you haven't had an in-person visit previously – Virtual visits are medical or mental health visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/video capabilities. – You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth. – Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment. – Telehealth services not covered by Medicare and not listed above are not covered.	
Physician, nurse practitioner, and nurse midwife services The plan covers physician, nurse practitioner, and nurse midwife services. These include, for example: • office visits for primary care and specialists • OB/GYN • diabetes self-management training • medical nutritional therapy • tobacco-cessation services	$0

Services that our plan pays for	What you must pay
Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes	$0 *Your provider may need to obtain prior authorization for some services.*
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services **include**: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	$0
Prostate cancer screening exams We pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0

Services that our plan pays for	What you must pay
Prosthetic and orthotic devices and related supplies Prosthetic devices replace all or part of a body part or function. These include but aren't limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.	$0 *Your provider may need to obtain prior authorization for some services.*
Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have a referral for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0 *Your provider may need to obtain prior authorization for some services.*
Remote patient monitoring The use of select medical devices that transmit digital personal health information in a synchronous or asynchronous manner from an at-risk patient to a treating provider at a distant location, enabling the provider to respond to the patient and manage their condition. RPM is available to members who meet certain clinical criteria.	$0

Services that our plan pays for	What you must pay
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your **primary care doctor or other qualified health care provider orders one and you meet one of these conditions**: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945–1965. If you were born between 1945–1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	$0
Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0

Services that our plan pays for	What you must pay
Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to **Chapter 12**. We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it's medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration • medical and surgical supplies given by SNFs • lab tests given by SNFs • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	$0 *Your provider must obtain prior authorization.*

Services that our plan pays for	What you must pay
Smoking and tobacco use cessation Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • are competent and alert during counseling • a qualified physician or other Medicare-recognized practitioner provides counseling We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).	$0
Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0 *Your provider may need to obtain prior authorization for some services.*

Services that our plan pays for	What you must pay
Transitional living services program The plan covers services provided by a transitional living services provider for members who qualify. These services are provided in a residential setting and may include the following: • personal care attendant services • on-site 24-hour nurse oversight • meals • skills trainers • assistance with Instrumental Activities of Daily Living (e.g., laundry, shopping, cleaning)	$0
Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • an unforeseeen illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider beause given your time, place, or circumstances, it's not possible, or it's unreasonable to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). Worldwide coverage for 'urgently needed services' when medical services are needed right away because of an illness, injury, or condition that you did not expect or anticipate, and you can't wait until you are back in our plan's service area to obtain services. Services provided by a dentist are not covered.	$0 for worldwide coverage of urgently needed services received outside of the United States. Please see Chapter 7 for expense reimbursement for worldwide services.

Services that our plan pays for	What you must pay
Vision care We pay for: • annual comprehensive eye exams • eye glasses • contact lenses and other visual aids We also pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes • African-Americans who are 50 and over • Hispanic Americans who are 65 and over For people with diabetes, we pay for screening for diabetic retinopathy once per year. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery.	$0 Plan pays up to $300 annually toward your purchase of frames (with standard lenses covered in full) or contact lenses (fitting and evaluation may be an additional cost). Home delivered eyewear is available nationwide through UnitedHealthcare Vision (select products only). You are responsible for all eyewear costs from providers outside of the UnitedHealthcare Vision network. *Your provider may need to obtain prior authorization for some services.*

Services that our plan pays for	What you must pay
“Welcome to Medicare” preventive visit We cover the one-time “Welcome to Medicare” preventive visit. The visit includes: • a review of your health, • education and counseling about preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.	$0
Wellness visit The plan covers wellness checkups. This is to make or update a prevention plan.	$0

In addition to the general services, our plan also covers community-based behavioral health care services. These are sometimes called “diversionary behavioral health services.” These are services that you may be able to use instead of going to the hospital or a facility for some behavioral health needs. Your Care Team will work with you to decide if these services are right for you and will be in your Individualized Care Plan (ICP).

Community-based (diversionary) behavioral health care services that our plan covers	
These services include the following: • Medically Monitored Intensive Services - Acute Treatment Services (ATS) for substance use disorders • clinically managed population-specific high intensity residential services* (refer to the Note below) • clinical stabilization services for substance use disorders • community crisis stabilization • Community Support Program (CSP), including CSP for homeless individuals, CSP for justice involved, and CSP Tenancy Preservation Program* • Adult Mobile Crisis Intervention (formerly Emergency Services Program (ESP)) You have the option of getting these services through an in-person visit or by telehealth. • Partial Hospitalization (PHP) services – "Partial hospitalization" is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center. It's more intense than the care you get in your doctor's, therapist's, or licensed marriage and family therapist's (LMFT) or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **This service is continued on the next page**	$0

Community-based (diversionary) behavioral health care services that our plan covers	
(continued) • Intensive Outpatient (IOP) services and IOP programs – Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided at a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that's more intense than the care received in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization. – An IOP program provides time-limited, comprehensive, and coordinated multidisciplinary treatment and are designed to improve Functional Status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. • Program of Assertive Community Treatment (PACT) • psychiatric day treatment • recovery coaching • recovery support navigators • Residential Rehabilitation Services for Substance User Disorders, including: – Adult RRS – Family RRS – Young Adult RRS – Co-occurring Enhanced RRS (COE-RRS) • Structured Outpatient Addiction Program (SOAP) • Enhanced Structured Outpatient Addiction Program (E-SOAP) • Transitional Support Services (TSS) for substance use disorders	$0

Our plan also covers community-based services to promote wellness, recovery, self-management of chronic conditions, and independent living. These services may also help you stay out of the hospital or nursing facility. Your Care Team will work with you to decide if these services are right for you and will be in your Individualized Care Plan (ICP).

Community-based services that our plan covers	
Care transitions assistance The plan pays covers services to help with transitions between care settings for members who qualify. These services may include the following: • coordination of information between your providers • follow-up after your inpatient or facility stay • education about your health condition • referrals	$0
Community health workers The plan covers services provided by community health workers, which may include the following: • health education in your home or community • getting you the services you need • counseling, support and screenings Services from a community health worker means that you'll be getting help from someone who'll advocate for you and who understands your culture, needs and preferences	$0
Day services The plan covers structured day activities at a program to help you learn skills that you need to live as independently as possible in the community. Skills are designed to meet your needs, and may include the following: • daily living skills • communication training • prevocational skills • socialization skills	$0

Community-based services that our plan covers	
Home care services The plan covers home care services provided in your home or community if you qualify. These services may include the following: • a worker to help you with household tasks • a worker to help you with your everyday tasks and personal care. Assistance can be hands-on, prompting, or supervising these tasks. • training or activities to improve your community living skills and help you advocate for yourself	$0
Home modifications The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, welfare and safety or make you more independent in your home. Modifications may include the following: • ramps • grab-bars • widening of doorways • special systems for medical equipment	$0
Medication management The plan covers medication management services from a support worker if you qualify. The support worker will help you take your prescription and over-the-counter medications. The service may include the following: • reminding you to take your medication • checking the medication package • watching you take your medication • writing down when you take your medication • opening medications and reading the labels for you	$0
Nonmedical transportation The plan covers transportation to community services and activities that help you stay independent and active in your community. The plan covers 10 one way trips per month.	$0

Community-based services that our plan covers	
Peer support/counseling/navigation The plan covers training, instruction, and mentoring services if you qualify. These services will help you to advocate for yourself and participate in your community. You may get these services from a peer or in small groups.	$0
Respite care The plan covers respite-care services if your primary caregiver needs relief or is going to be unavailable for a short-term basis. These services can be provided in an emergency or be planned in advance. If planned in advance, services might be in your home, or during a short-term placement in adult foster care, adult day health, nursing facility, assisted living, rest home, or hospital.	$0

Section E Benefits covered outside of our plan

We don't cover the following services, but they're available through MassHealth (Medicaid).

Section E1 State Agency Services

Psychosocial Rehabilitation and Targeted Case Management

If you're getting Psychosocial Rehabilitation from the Department of Mental Health or Targeted Case Management from the Department of Mental Health or Department of Developmental Services, your services will continue to be provided directly from the state agency. However, UHC Senior Care Options will assist in coordinating with these providers as a part of your overall Individualized Care Plan (ICP).

Rest Home Room and Board

If you live in a rest home and join Senior Care Options (SCO), the Department of Transitional Assistance will continue to be responsible for your room and board payments.

Section F Benefits not covered by our plan, Medicare, or MassHealth (Medicaid)

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and MassHealth (Medicaid) don't pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don't pay for excluded medical benefits listed in this section (or anywhere else in this **Member Handbook**) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won't pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this **Member Handbook**.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn't cover the following items and services:

- services considered not "reasonable and medically necessary", according Medicare and MassHealth (Medicaid) standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this **Member Handbook** for more information on clinical research studies. Experimental treatment and items

are those that aren't generally accepted by the medical community.

- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- meals delivered to your home
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and behavioral performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- regular hearing exams, hearing aids, or exams to fit hearing aids
- radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we'll reimburse the veteran for the difference.

Chapter 5

Getting your outpatient drugs

Chapter 5

Getting your outpatient drugs

Introduction

This chapter explains rules for getting your outpatient drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and MassHealth (Medicaid). Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

We also cover the following drugs, although they're not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you're in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you're given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of this **Member Handbook**.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5, Section D** "If you're in a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section.

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists or any similar MassHealth (Medicaid) lists.

You generally must use a network pharmacy to fill your prescription (Refer to **Section A1** for more information). Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on our plan's **List of Covered Drugs**. We call it the "**Drug List**" for short. (Refer to **Section B** of this chapter.)

- If it isn't on the **Drug List,** we may be able to cover it by giving you an exception.
- Refer to **Chapter 9** to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug.

Your drug may require approval from our plan based on certain criteria before we'll cover it. (Refer to **Section C** in this chapter.)

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Section A Getting your prescriptions filled

Section A1 Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

To find a network pharmacy, refer to the **Provider and Pharmacy Directory**, visit our website or contact Member Services or your Care Manager.

Section A2 Using your UCard when you fill a prescription

To fill your prescription, **show your UCard** at your network pharmacy. The network pharmacy bills us for your covered drug.

If you don't have your UCard with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back. **If you can't pay for the drug, contact Member Services right away.** We'll do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of this **Member Handbook**.
- If you need help getting a prescription filled, contact Member Services or your Care Manager.

Section A3 What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services or your Care Manager.

Section A4 What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, refer to the **Provider and Pharmacy Directory**, visit our website, or contact Member Services or your Care Manager.

Section A5 Using a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy isn't in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.) To find a specialized pharmacy, refer to the **Provider and Pharmacy Directory**, visit our website, or contact Member Services: or your Care Manager.

Section A6 Using mail-order services to get your drugs

Our plan's mail-order service requires you to order at least a 30 day supply of the drug and no more than a 100-day supply. A 30-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail.

Usually, a mail-order prescription arrives within 10 days If your prescription is on file at your local pharmacy, go to your pharmacy to fill the prescription. If your delayed prescription is not on file at your local pharmacy, then please ask your doctor or provider to call in a new prescription to your pharmacist. Or, your pharmacist can call the doctor's office for you to request the prescription. Your pharmacist can call the Pharmacy help desk at **1-877-889-6510**, (TTY) **711**, 24 hours a day, 7 days a week if he/she has any problems, questions, concerns, or needs a claim override for a delayed prescription.

Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

1. **New prescriptions the pharmacy gets from you**

   The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets from your provider's office**

After the pharmacy gets a prescription from a health care provider, it contacts you to find out if you want the medication filled immediately or at a later time.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allows you to stop or delay the order before it's shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. **New prescriptions the pharmacy gets from your provider's office**

   The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

   - You used mail-order services with our plan in the past, **or**
   - You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by phone or mail.

   If you used mail-order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by phone or mail.

   If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

   - This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before it's shipped.
   - Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

   To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by phone or mail.

4. **Refills on mail-order prescriptions**

   For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

   - The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.
   - If you choose not to use our auto refill program, contact your pharmacy 10 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by phone or mail.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. **You can do this by contacting the mail order pharmacy when you set up your auto refill program and also when you receive notifications about upcoming refill shipments.**

Section A7 Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's **Drug List**. Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a one-month supply. The **Provider and Pharmacy Directory** tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also speak to your Care Manager or Member Services for more information.

For certain kinds of drugs, you can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.

Section A8 Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. In these cases, check with your Care Manager or Member Services first to find out if there's a network pharmacy nearby.

We pay for prescriptions filled at an out-of-network pharmacy in the United States for the following cases:

- **Prescriptions for a medical emergency**

  We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our **Drug List** without restrictions, and are not excluded from Medicare Part D coverage.

- **Coverage when traveling or out of the service area**

  When traveling within the U.S. you have access to network pharmacies nationwide. Bring your prescriptions and medication with you and be sure to check the pharmacy directory for your travel plans to locate a network pharmacy while traveling. If you are leaving the country, you may be able to obtain a greater day supply to take with you before leaving for the country where there are no network pharmacies available.

- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy that provides 24-hour service is not within reasonable driving distance.

- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- If you need a prescription while a patient in an emergency department, provider based clinic, outpatient surgery, or other outpatient setting.
- Any prescriptions filled outside of the United States are not covered.

Section A9 Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost when you get your prescription. You can ask us to pay you back. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

To learn more about this, refer to **Chapter 7** of this **Member Handbook**.

Section B Our plan's Drug List

We have a **List of Covered Drugs**. We call it the "**Drug List**" for short.

We select the drugs on the **Drug List** with the help of a team of doctors and pharmacists. The **Drug List** also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's **Drug List** when you follow the rules we explain in this chapter.

Section B1 Drugs on our Drug List

Our **Drug List** includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under MassHealth (Medicaid).

Certain drugs may be covered for some medical conditions but considered non-formulary for other medical conditions. These drugs will be identified on our **Drug List** and in Medicare.gov, along with the specific medical condition that they cover.

Our **Drug List** includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On our **Drug List**, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name or original biological products and usually cost less. There are generic drug substitutes

available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the **Drug List**.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

Section B2 How to find a drug on our Drug List

To find out if a drug you take is on our **Drug List**, you can:

- Visit our plan's website at **myUHC.com/CommunityPlan**. The **Drug List** on our website is always the most current one.
- Call your Care Manager or Member Services to find out if a drug is on our **Drug List** or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at **myUHC.com/CommunityPlan** to search for drugs on the **Drug List** to get an estimate of what you'll pay and if there are alternative drugs on the **Drug List** that could treat the same condition. You can also call your Care Manager or Member Services.

Section B3 Drugs not on our Drug List

We don't cover all drugs.

- Some drugs aren't on our **Drug List** because the law doesn't allow us to cover those drugs.
- In other cases, we decided not to include a drug on our **Drug List**.
- In some cases, you may be able to get a drug that isn't on our **Drug List**. For more information refer to **Chapter 9**.

Our plan doesn't pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of this **Member Handbook** for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and MassHealth (Medicaid) drugs) can't pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits.

2. Our plan can't cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or MassHealth (Medicaid) can't cover the types of drugs listed below.

- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Outpatient drugs made by a company that says you must have tests or services done only by them

Section C Limits on some drugs

For certain drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

Note that sometimes a drug may appear more than once in our **Drug List**. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

If there's a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule shouldn't apply to your situation, ask us to use the coverage decision process to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of this **Member Handbook**.

1. **Limiting use of a brand name drug or original biological when, respectively, a generic or interchangeable biosimilar version is available**

   Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. In most cases, if there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you, the generic or interchangeable biosimilar version.

- We usually don't pay for the brand name drug or original biological product when there's an available generic version.
- However, if your provider told us the medical reason that the generic drug or interchangeable biosimilar won't work for you or wrote "No substitutions" on your prescription for a brand name drug or original biological product or told us the medical reason that the generic drug, interchangeable biosimilar, or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.

2. **Getting plan approval in advance**

   For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get approval, we may not cover the drug. Call Member Services at the number at the bottom of the page or on our website at **myUHC.com/CommunityPlan** for more information about prior authorization.

3. **Trying a different drug first**

   In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

   If Drug A doesn't work for you, then we cover Drug B. This is called step therapy. Call Member Services at the number at the bottom of the page or on our website at **myUHC.com/CommunityPlan** for more information about step therapy.

4. **Quantity limits**

   For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our **Drug List**. For the most up-to-date information, call Member Services or check our website at **myUHC.com/CommunityPlan**. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of this **Member Handbook**.

Section D Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our **Drug List**. We may cover a generic version of the drug but not the brand name version you want to take.

A drug may be new, and we haven't reviewed it for safety and effectiveness yet.

- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

Section D1 Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug isn't on our **Drug List** or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you've been taking:
   - is no longer on our **Drug List or**
   - was never on our **Drug List or**
   - is now limited in some way.
2. You must be in one of these situations:
   - You were in our plan last year.
     - We cover a temporary supply of your drug during the first 90 days of the calendar year.
     - This temporary supply is for up to 30 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
   - You're new to our plan.
     - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan**.
     - This temporary supply is for up to 30 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
   - You've been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.

  - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.

For MassHealth (Medicaid) drugs:

- You're new to the plan.
  - We'll cover a supply of your MassHealth (Medicaid) drug for 90 days or until your comprehensive assessment and Care Plan are complete, or less if your prescription is written for fewer days.
  - To ask for a temporary supply of a drug, call Member Services at **1-888-867-5511**.

Section D2 Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

  OR

- Ask for an exception.

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that isn't on our **Drug List** or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

Section D3 Asking for an exception

If a drug you take will be taken off our **Drug List** or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).
- If we approve your request, we'll authorize coverage for the drug before the change takes effect.

To learn more about asking for an exception, refer to **Chapter 9** of this **Member Handbook**.

If you need help asking for an exception, contact Member Services or your Care Manager.

Section E Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our **Drug List** during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change our plan's **Drug List**. For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally won't remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on our **Drug List** now, **or**
- we learn that a drug isn't safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you're taking?

To get more information on what happens when our **Drug List** changes, you can always:

- Check our current **Drug List** online at **myUHC.com/CommunityPlan or**
- Call Member Services at the number at the bottom of the page to check our current **Drug List**.

Changes we may make to the Drug List that affect you during the current plan year

Some changes to the **Drug List** will happen immediately. For example:

A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the **Drug List** now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same. When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we'll send you information about the specific change we made once it happens.
- You or your provider can ask for an "exception" from these changes. We'll send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of this handbook for more information on exceptions.

Removing unsafe drugs and other drugs that are taken off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our **Drug List**. If you're taking the drug, we'll send you a notice after we make the change

We may make other changes that affect the drugs you take. We tell you in advance about these other changes to our **Drug List**. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our **Drug List or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there's a similar drug on our **Drug List** you can take instead **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this **Member Handbook**.

Changes to the Drug List that don't affect you during this plan year

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you're taking or limit its use, then the change doesn't affect your use of the drug or what you pay for the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you above these types of changes directly during the current year. You'll need to check the **Drug List** for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan year.

Section F Drug coverage in special cases

Section F1 In a hospital or a skilled nursing facility for a stay that our plan covers

If you're admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your drugs during your stay. You won't pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

Section F2 In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your drugs through the facility's pharmacy if it's part of our network.

Check your **Provider and Pharmacy Directory** to find out if your long-term care facility's pharmacy is part of our network. If it isn't or if you need more information, contact Member Services.

Section F3 In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice doesn't cover because it isn't related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of this **Member Handbook** for more information about the hospice benefit.

Section G Programs on drug safety and managing drugs

Section G1 Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you take another similar drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of drugs, we work with your provider to correct the problem.

Section G2 Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over the counter medication

Then, they'll give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your prescriber about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you don't want to be in the program, let us know, and we'll take you out of it.

If you have questions about these programs, contact Member Services or your Care Manager.

Section G3 Drug management program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescriber to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescriber, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may include:

- Requiring you to get all prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to medications, we'll automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this **Member Handbook**.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6

What you pay for your Part D prescription drugs

Chapter 6

What you pay for your Medicare and MassHealth drugs

Introduction

This chapter tells what you pay for your outpatient drugs. By "drugs," we mean:

- Medicare Part D drugs, **and**
- Drugs and items covered under Medicaid, **and**
- Drugs and items covered by our plan as additional benefits.

Because you're eligible for MassHealth (Medicaid) you get Extra Help from Medicare to help pay for your Medicare Part D drugs.

Extra Help is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS." **As a Senior Care Options (SCO) member, MassHealth covers the remaining costs that Medicare doesn't for Medicare Part D drug costs.**

Other key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

To learn more about drugs, you can look in these places:

- Our **List of Covered Drugs**.
  - We call this the **Drug List**. It tells you:
    - Which drugs we pay for
    - If there are any limits on the drugs
  - If you need a copy of our **Drug List**, call Member Services. You can also find the most current copy of our **Drug List** on our website at **myUHC.com/CommunityPlan**.
- **Chapter 5** of this **Member Handbook**.
  - It tells how to get your outpatient drugs through our plan.
  - It includes rules you need to follow. It also tells which types of drugs our plan doesn't cover.
  - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is an estimate of the out-of-pocket costs you're expected to pay. You can call your care coordinator or Member Services for more information.

- Our **Provider and Pharmacy Directory**.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The **Provider and Pharmacy Directory** lists our network pharmacies. Refer to **Chapter 5** of this **Member Handbook** for more information about network pharmacies.

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Section A The Explanation of Benefits (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get drugs through our plan, we send you a summary called the **Explanation of Benefits**. We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month.** The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives.** When applicable, information about other available drugs with lower cost sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- We also pay for some over-the-counter drugs. You don't have to pay anything for these drugs.
- To find out which drugs our plan covers, refer to our **Drug List**. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under MassHealth. These drugs are included in the **Drug List**.

Section B How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. **Use your Member ID Card.**

Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. **Make sure we have the information we need.**

   Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for the drug.

   Here are examples of when you should give us copies of your receipts:

   - When you buy a covered drug at a network pharmacy at a special price or use a discount card that isn't part of our plan's benefit
   - When you pay a copay for drugs that you get under a drug maker's patient assistance program
   - When you buy covered drugs at an out-of-network pharmacy
   - When you pay the full price for a covered drug under special circumstances

   For more information about asking us to pay you back for a drug, refer to **Chapter 7** of this **Member Handbook**.

3. **Send us information about payments others make for you.**
4. **Check the EOBs we send you.**

   When you get an EOB in the mail, make sure it's complete and correct.

   - **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
   - **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at UHC Senior Care Options Member Services. You can also find answers to many questions on our website: **myUHC.com/CommunityPlan**.

What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at UHC Senior Care Options Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free.

If you think something is wrong or missing, or if you have any questions, call Member Services. Keep these EOBs. They're an important record of your drug expenses.

Section C You pay nothing for a one-month or long-term supply of drugs

With our plan, you pay nothing for covered drugs as long as you follow our rules.

Important message about what you pay for covered insulin – You will pay a maximum of $0 for each 1-month supply of Part D covered insulin drug.

Refer to **Chapter 9** of this **Member Handbook** to learn about how to file an appeal if you're told a drug won't be covered. To learn more about these pharmacy choices, refer to **Chapter 5** of this **Member Handbook** and our **Provider and Pharmacy Directory**.

Section C1 Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. There's no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this **Member Handbook** or our **Provider and Pharmacy Directory**.

For information about which pharmacies can give you long-term supplies, refer to our plan's **Provider and Pharmacy Directory**.

Section D What you pay for Part D vaccines

Important message about what you pay for vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our **Drug List**. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's **Drug List** or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccines:

1. The first part is for the cost of the vaccine itself.
2. The second part is for the cost of giving you the vaccine. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

Section D1 What you need to know before you get a vaccine

We recommend that you call Member Services if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine.

Chapter 7

Asking us to pay a bill you got for covered services or drugs

Chapter 7

Asking us to pay a bill you got for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you don't agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

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Section A Asking us to pay for your services or drugs

You shouldn't get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We don't allow **UHC Senior Care Options** providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, don't pay the bill and send the bill to us. To send us a bill, refer to **myUHC.com/CommunityPlan**.

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it's your right to be paid back.
  - If you paid for services covered by Medicare, we'll pay you back.
  - If you paid for services covered by MassHealth (Medicaid) we can't pay you back, but the provider or MassHealth (Medicaid) will. Member Services or your Care Manager and/or ombudsperson can help you contact the provider's office. Refer to the bottom of the page for the Member Services phone number.
- If we don't cover the services or drugs, we'll tell you.

Contact Member Services or your Care Manager if you have any questions. If you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
     - If the provider should be paid, we'll pay the provider directly.
     - If you already paid for the Medicare service, we'll pay you back.
   - You can also receive emergency or urgently needed services from a provider outside the United States. If you receive emergency or urgently-needed services outside of the United States, the provider may require that you pay for the cost of the services in full. Ask for a written, detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt to us to pay you back. You should be prepared to assist us in obtaining all of the information necessary to properly process your request

for reimbursement, including medical records. Foreign emergency and urgently needed care is covered only if paid directly by you and submitted to us for reimbursement, or when reimbursement is requested directly by you and when we can make arrangements to pay the rendering provider directly. Invoices and supporting medical records must be submitted directly by you or directly by the rendering provider. Any services or documentation submitted to us by third-party billers, intermediaries or claims management companies are not reimbursable.

2. **When a network provider sends you a bill**

   Network providers must always bill us. It's important to show your UCard when you get any services or prescriptions. But sometimes they make mistakes and ask you to pay for your services or more than your share of the costs. **Call Member Services** or your Care Manager at the number at the bottom of this page **if you get any bills**.

   - Because we pay the entire cost for your services, you aren't responsible for paying any costs. Providers shouldn't bill you anything for these services.
   - Whenever you get a bill from a network provider, send us the bill. We'll contact the provider directly and take care of the problem.
   - If you already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We'll pay you back for your covered services or for the difference between the amount you paid and the amount you owed under our plan.

3. **If you're retroactively enrolled in our plan**

   Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

   - If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
   - Send us the bill and proof of any payment you made.

4. **When you use an out-of-network pharmacy to fill a prescription**

   If you use an out-of-network pharmacy, you pay the full cost of your prescription.

   - In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
   - Refer to **Chapter 5** of this **Member Handbook** to learn more about out-of-network pharmacies.
   - We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. **When you pay the full Medicare Part D prescription cost because you don't have your UCard with you**

   If you don't have your UCard with you, you can ask the pharmacy to call us or look up your plan enrollment information.

   - If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your UCard.
   - Send us a copy of your receipt when you ask us to pay you back.
   - We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. **When you pay the full prescription cost for a drug that's not covered**

   You may pay the full prescription cost because the drug isn't covered.

   - The drug may not be on our **List of Covered Drugs (Drug List)** on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
     - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of this **Member Handbook**).
     - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of this **Member Handbook**).
   - Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

7. **When you utilize your worldwide emergency coverage, worldwide urgently needed services, or worldwide emergency transportation benefits**

   Important: If you are admitted to a hospital following a medical emergency while traveling outside the United States, call Member Services immediately using the number on your health plan ID card. This ensures timely coordination of care and access to support.

   You will pay the full cost of emergency services received outside of the United States at the time you receive services. To receive reimbursement from us, you must do the following:

   - Pay your bill at the time it is received. We will reimburse you for the difference between the amount of your bill and your cost share for the services as outlined in Chapter 4 and the Exclusions sections of this document.
   - Save all of your receipts and send us copies when you ask us to reimburse you. In some situations, we may need to get more information from you or the provider who rendered

services to you in order to pay you back for our share of the cost.

- If you are being asked to pay your bill for worldwide emergency services and are unable to make the payment, please call Member Services for additional assistance and we may be able to work directly with the rendering provider to help coordinate payment for covered services on your behalf. You must request payment for foreign services directly from us, and you or the rendering provider must submit all documentation directly to us.
- Payment requests from intermediaries, claims management companies or third-party billers that are separate from the rendering provider are not reimbursable. We never provide forms to foreign providers, claims management companies, or third-party billers that would require your signature and/or a deposit or payment by you in order for you to receive reimbursement from us. In some countries, you may be asked to pay a deposit or sign forms, and the provider will represent that they will collect the rest from us directly. However, forms that a foreign provider, claims management company, or third-party biller submits to us on your behalf will not be reimbursed by us, even if those forms include the UHC name or logo. We will only consider requests for reimbursement for medical services that you receive from a foreign provider that you submit to us directly. This allows us to confirm that you received the services, and that you are being reimbursed the same amount that you were billed or paid at the time the service was rendered.
- If you receive any services in a foreign country that are not covered worldwide emergency or urgently needed services as described in this Member Handbook, you are fully responsible for payment for those services. Neither the plan nor Medicare will pay for services received outside of the United States that are not explicitly described as covered in this Member Handbook.
- You must request reimbursement from the Health Plan within 12 months from the date services are received. You must provide the following documentation with your submission:
  1. An itemized bill from the facility including the hospital's name, your's name, dates of stay, a list of charges, a brief description of each charge, and a total.
  2. A receipt/proof of payment showing that the amount on the bill was paid. Acceptable proofs of payment are credit card receipt, canceled check or bank statement. For cash payments, a provider's itemized invoice showing cash payment was made and detailing any remaining balance is acceptable.
  3. A copy of the medical record or documentation describing the medical situation and treatment course.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide whether the service or drug should be covered, we pay for it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of this **Member Handbook**.

Section B Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.**

To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website (**myUHC.com/CommunityPlan**), or you can call Member Services and ask for the form.

Mail your request for payment together with any bills or receipts to this address:

Part D Prescription drug payment requests:

Optum Rx
P.O. Box 650287
Dallas, TX 75265-0287

Medical claims payment requests:

UnitedHealthcare
P.O. Box 1350
Salt Lake City, UT 84131-0350

Section C Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay for it. If you already paid for the service or drug, we'll mail you a check. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

Chapter 3 of this **Member Handbook** explains the rules for getting your services covered. **Chapter 5** of this **Member Handbook** explains the rules for getting your Medicare Part D drugs covered.

- If we decide not to pay for the service or drug, we'll send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9**.

Section D Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making an appeal." You can also make an appeal if you don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of this **Member Handbook**: To make an appeal about getting paid back for a health care service, refer to **Section F**.

- To make an appeal about getting paid back for a drug, refer to **Section G**.

Chapter 8

Your rights and responsibilities

Chapter 8

Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

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Section A Your right to get services and information in a way that meets your needs

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call Care Manager or Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English including Spanish and in formats such as large print, braille, or audio. To get materials in one of these alternative formats, please call Member Services or write to <Plan name, address.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- My Ombudsman at 1-855-781-9898, Monday through Friday from 9:00 a.m. to 4:00 p.m.
  - Use 7-1-1 to call 1-855-781-9898. This number is for people who are deaf, hard of hearing, or speech disabled.
  - Use Videophone (VP) 339-224-6831. This number is for people who are deaf or hard of hearing.
- MassHealth (Medicaid) Customer Service Center at 1-800-841-2900, Monday through Friday, from 8:00 a.m. to 5:00 p.m. (TTY: 711).
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

Section B Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this **Member Handbook**.
  - Call Care Manager or Member Services or go to the **Provider and Pharmacy Directory** to learn more about network providers and which doctors are accepting new patients.

- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that isn't your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that's urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of this **Member Handbook**.

Chapter 9 of this **Member Handbook** tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

Section C Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes the personal information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

Section C1 How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws.

Section C2 Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your PHI, call Member Services.

Section D Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. We can also give you information in large print, braille, or audio.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:

  - services (refer to **Chapters 3 and 4** of this **Member Handbook**) and drugs (refer to **Chapters 5 and 6** of this **Member Handbook**) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this **Member Handbook**), including asking us to:
  - put in writing why something isn't covered
  - change a decision we made
  - pay for a bill you got

Section E Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this **Member Handbook**.

Section F Your right to leave the plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.
- Refer to **Chapter 10** of this **Member Handbook**:
  - For more information about when you can join a new MA or drug benefit plan.
  - For information about how you'll get your MassHealth (Medicaid) benefits if you leave our plan.

Section G Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

Section G1 Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we won't drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of this **Member Handbook** tells how to ask us for a coverage decision.

Section G2 Your right to say what you want to happen if you can't make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you **don't** want.

The legal document you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You aren't required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a social worker, or some office supply stores. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form.

- **Fill out the form and sign it.** The form is a legal document. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** Give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.
- If you're being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Member Services for more information.

Section G3 What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with Massachusetts Serving the Health Insurance Needs of Everyone (SHINE) **1-800-243-4636**.

Section H Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9 of this **Member Handbook** tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

Section H1 What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly — and it isn't about discrimination for reasons listed in **Chapter 11** of this **Member Handbook** — or you want more information about your rights, you can call:

- Member Services.
- The SHINE (Serving the Health Insurance Needs of Everyone) program at **1-800-243-4636**. For more details about SHINE (Serving the Health Insurance Needs of Everyone), refer to **Chapter 2**.
- My Ombudsman at 1-855-781-9898 (Toll Free), Monday through Friday from 9:00 a.m. to 4:00 p.m.
  - Use 7-1-1 to call 1-855-781-9898. This number is for people who are deaf, hard of hearing, or speech disabled.
  - Use Videophone (VP) 339-224-6831. This number is for people who are deaf or hard of hearing.
  - Email My Ombudsman at **info@myombudsman.org**.

My Ombudsman is an independent program that can help you address concerns or conflicts with your enrollment in Senior Care Options (SCO) or your access to SCO benefits and services.

Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at **www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf**.)

MassHealth (Medicaid) at 1-800-841-2900, Monday through Friday, from 8:00 a.m. to 5:00 p.m. (TTY: 711).

Section I Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read this Member Handbook** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of this **Member Handbook**. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of this **Member Handbook**.

- **Tell us about any other health or drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you're a member of our plan. Show your UCard when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most UHC Senior Care Options (HMO D-SNP) members, MassHealth (Medicaid) pays for your Medicare Part A premium and for your Medicare Part B premium.
  - **If you get any services or drugs that aren't covered by our plan, you must pay the full cost. (Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call Care Manager or Member Services.
  - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this **Member Handbook** tells about our service area.
  - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and MassHealth (Medicaid) your new address when you move. Refer to **Chapter 2** of this **Member Handbook** for phone numbers for Medicare and MassHealth (Medicaid).
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.

  - **If you move, tell Social Security (or the Railroad Retirement Board).**
- **Call Care Manager or Member Services for help if you have questions or concerns.**

Chapter 9

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Chapter 9

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you're looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.** This chapter is broken into different sections to help you easily find information about what to do for your problem or concern.

If you're facing a problem with your services

You should get the medical services, behavioral health services, drugs, and long-term services and supports (LTSS) that are necessary for your care as a part of your Individualized Care Plan (ICP). **If you're having a problem with your care, you can call My Ombudsman at 1-855-781-9898 (or by using MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831)**. This chapter explains the options you have for different problems and complaints, but you can also call My Ombudsman to help you with your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** for more information about My Ombudsman.

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Section A What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints** (also called grievances).

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

Section A1 About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination”, “benefit determination”, “at-risk determination”, or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” (IRO) instead of “Independent Review Entity” (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

Section B Where to get help

Section B1 For more information and help

Sometimes it’s confusing to start or follow the process for dealing with a problem. This can be especially true if you don’t feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from the State Health Insurance Assistance Program (SHIP)

You can call the State Health Insurance Assistance Program (SHIP). SHINE counselors can answer your questions and help you understand what to do about your problem. SHINE isn’t connected with us or with any insurance company or health plan. SHINE has trained counselors in every county, and services are free. The SHINE phone number is 1-800-243-4636 and their website is http://www.mass.gov/elders/healthcare/shine/serving-the-healthinformation-needs-of-elders.html. TTY (for people who are deaf, hard of hearing, or speech disabled): 1-800-439-2370

(Massachusetts only).

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from MassHealth (Medicaid)

You can call MassHealth (Medicaid) Customer Service directly for help with problems. Call 1-800-841-2900. TTY (for people who are deaf, hard of hearing, or speech disabled): 711.

Help from My Ombudsman

My Ombudsman is an independent program that can help you if you have questions, concerns, or problems related to Senior Care Options (SCO). You can contact My Ombudsman to get information or help to resolve any issue or problem with your SCO plan. My Ombudsman's services are free. Information about My Ombudsman may also be found in **Chapter 2**. My Ombudsman's staff:

- Can answer your questions or refer you to the right place to find what you need.
- Can help you address a problem or concern with SCO or your SCO plan, UHC Senior Care Options. My Ombudsman's staff will listen, investigate the issue, and discuss options with you to help solve the problem.
- Help with appeals. An appeal is a formal way of asking your SCO plan, MassHealth (Medicaid), or Medicare to review a decision about your services. My Ombudsman's staff can talk with you about how to make an appeal and what to expect during the appeal process.

You can call, email, write, or visit My Ombudsman at its office.

- Call 1-855-781-9898, Monday through Friday from 9:00 a.m. to 4:00 p.m. People who are deaf, hard of hearing, or speech disabled should use MassRelay at 711 to call 1 855-781-9898 or Videophone (VP) 339-224-6831.
- Email info@myombudsman.org
- Write to or visit My Ombudsman's office at 25 Kingston Street, 4th floor, Boston, MA 02111.
  - Please refer to the My Ombudsman website or contact them directly for updated information about location, appointments, and walk-in hours.
- Visit My Ombudsman online at www.myombudsman.org

Section C Understanding Medicare and MassHealth (Medicaid) complaints and appeals in our plan

You have Medicare and MassHealth (Medicaid). Information in this chapter applies to **all** your Medicare and MassHealth (Medicaid) benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and MassHealth (Medicaid) processes.

Sometimes Medicare and MassHealth (Medicaid) processes can't be combined. In those situations, you use one process for a Medicare benefit and another process for a MassHealth (Medicaid) benefit. **Section F4** explains these situations.

Section D Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage.	**No.** My problem isn't about benefits or coverage.
Refer to **Section E:** "Coverage decisions and appeals".	Refer to **Section K:** "How to make a complaint".

Section E Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Part B drugs as **medical care**.

Section E1 Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4, Section H** of this **Member Handbook**).

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we'll cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or MassHealth (Medicaid). If you disagree with this coverage decision, you can make an appeal.

Section E2 Appeals

If we make a coverage decision and you aren't satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we'll send you a letter. If your problem is about coverage of a Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or MassHealth (Medicaid) service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals.

If you aren't satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

Section E3 Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- Call your Care Manager.
- Call, email, write, or visit **My Ombudsman**.
  - Call 1-855-781-9898, Monday through Friday from 9:00 a.m. to 4:00 p.m. People who are deaf, hard of hearing, or speech disabled should use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831.
  - Email info@myombudsman.org.
  - Visit My Ombudsman online at www.myombudsman.org.
  - Write to or visit the My Ombudsman office at 25 Kingston Street, 4th floor, Boston, MA 02111.
    - Please refer to the My Ombudsman website or contact them directly for updated information about location, appointments, and walk-in hours.
- **State Health Insurance Assistance Program (SHIP)** for free help. In Massachusetts, the SHIP is called SHINE. SHINE is an independent organization. It is not connected with this plan. The SHINE phone number is 1-800-243-4636. TTY (for people who are deaf, hard of hearing, or speech disabled): 1-800-439-2370 (Massachusetts only).
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. **You must give us a copy of the signed form.**

Section E4 Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, "Medical care"
- **Section G**, "Medicare Part D drugs"
- **Section H**, "Asking us to cover a longer hospital stay"
- **Section I**, "Asking us to continue covering certain medical services" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page.

Section F Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care.

This section is about your benefits for medical care that's described in **Chapter 4** of this **Member Handbook** in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

Section F1 Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but aren't getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we won't pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.
   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

Section F2 Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: **1-888-867-5511**, TTY: **711**.
- Faxing: **1-888-950-1170**
- Writing:

  UnitedHealthcare Customer Service Department (Organization Determinations)
  P.O. Box 30770, Salt Lake City, UT 84130-0770

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer within:

- **7 calendar days** after we get your request **for a medical service or item that is subject to our prior authorization rules**
- **14 calendar days** after we get your request **for all other medical services or items**.
- **72 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we'll tell you in writing. **We can't take extra days if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.

Fast coverage decision

The legal term for fast coverage decision is **expedited determination**.

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we'll give you an answer within:

- **72 hours** after we get your request **for a medical service or item**.
- **24 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we'll tell you in writing. **We can't take extra time if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We'll call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You're asking for coverage for medical items and/or services that you **didn't get**. You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process refer to **Section F**.

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

Section F3 Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at **1-888-867-5511**.

Additionally, if you need help during the appeals process, you can call My Ombudsman at 1-855-781-9898 (or use MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831). My Ombudsman is not connected with us or with any insurance company or health plan.

Ask for a standard appeal or a fast appeal in writing or by calling us at **1-888-867-5511**.

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.

- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

The legal term for "fast appeal" is "**expedited reconsideration**."

- If you appeal a decision we made about coverage for care, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
  - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
  - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a MassHealth (Medicaid) service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up.
- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request**, we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If you think we **shouldn't** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.

- If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a MassHealth (Medicaid) service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a MassHealth (Medicaid) service or item, the letter tells you how to file a Level 2 Appeal yourself.

Section F4 Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, MassHealth (Medicaid), or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that MassHealth (Medicaid) usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and MassHealth (Medicaid)** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by MassHealth (Medicaid), your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the Independent Review Organization (IRO) is the **Independent Review Entity**, sometimes called the **IRE**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have the right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO take extra time to make a decision if your request is for a Medicare Part B drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service,** we must:
  - Authorize the medical care coverage **within 72 hours**, or
  - Provide the service within **14 calendar days** after we get the IRO's decision for **standard requests, or**

  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says No to part or all of your appeal**, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item MassHealth (Medicaid) usually covers, or that's covered by both Medicare and MassHealth (Medicaid)

A Level 2 Appeal for services that MassHealth (Medicaid) usually covers is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

Section F5 Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of this **Member Handbook**. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you're asking for a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we'll send you the payment for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request. Your provider will then send the payment to you.
- If you haven't paid for the service or item yet, we'll send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item isn't covered or you did not follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter

explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and MassHealth (Medicaid) usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that MassHealth (Medicaid) may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this **Member Handbook** for more information about a medically accepted indication.

Section G Medicare Part D drugs

Section G1 Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that isn't on our plan's **Drug List** or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's **Drug List** but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a "**coverage determination**."

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our **Drug List** or need us to set aside a rule or restriction on a drug we cover. **You can ask us to make an exception.** (This is a type of coverage decision.)	You want us to cover a drug on our **Drug List**, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need. **You can ask us for a coverage decision.**	You want to ask us to pay you back for a drug you already got and paid for. **You can ask us to pay you back.** (This is a type of coverage decision.)	We told you that we won't cover or pay for a drug in the way that you want. **You can make an appeal.** (This means you are asking us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4**.	Refer to **Section G4**.	Refer to **Section G4.**	Refer to **Section G5**.

Section G2 Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our **Drug List** or for removal of a restriction on a drug is sometimes called asking for a "**formulary exception**."

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering exception**.

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that isn't on our Drug List**
   - We can agree to make an exception and cover a drug that isn't on our **Drug List**.

2. **Removing a restriction for a covered drug**
   - Extra rules or restrictions apply to certain drugs on our **Drug List** (refer to **Chapter 5** of this **Member Handbook** for more information).
   - Extra rules and restrictions for certain drugs include:
     - Being required to use the generic version of a drug instead of the brand name drug.
     - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
     - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
     - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

Section G3 Important things to know about asking an exceptions

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our **Drug List** often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

Section G4 Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling **1-888-867-5511**, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.

- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this **Member Handbook**.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

A "fast coverage decision" is called an "**expedited coverage determination**."

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Section G5 Making a Level 1 Appeal

An appeal to our plan about a Medicare Part D drug coverage decision is called a plan "**redetermination**".

- Start your **standard** or **fast appeal** by calling **1-888-867-5511**, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

A fast appeal is also called an "**expedited redetermination**."

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.

- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Section G6 Making a Level 2 Appeal

If we say No to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The IRO reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

The formal name for the "Independent Review Organization" (IRO) is the "**Independent Review Entity**", sometimes called the "**IRE**".

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file.**
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage

you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section H Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this **Member Handbook**.

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

Section H1 Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1 800-MEDICARE (1-800-633-4227). TTY users should call 1 877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing **doesn't** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1 800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section H2 Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In Massachusetts, the QIO is KEPRO. Call them at 1-888-319-8452. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave,** you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal,** and you decide to stay in the hospital after your planned discharge

date, you may pay all costs for hospital care you get after your planned discharge date.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call SHINE (Serving the Health Insurance Needs of Everyone) .

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

The legal term for "**fast review**" is "**immediate review**" or "**expedited review**."

What happens during the fast review?

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the "**Detailed Notice of Discharge**." You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO

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gives you their answer to your appeal.

- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

Section H3 Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at **1-888-319-8452**.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ends.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs from noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section I Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're

getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section I1 Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice only shows that you got the information. Signing **doesn't** mean you agree with our decision.

Section I2 Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the SHINE (Serving the Health Insurance Needs of Everyone)
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of this **Member Handbook** for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

The legal term for the written notice is "**Notice of Medicare Non-Coverage**". To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is "**Detailed Explanation of Non-Coverage**".

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

Section I3 Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-319-8452.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1

Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section J Taking your appeal beyond Level 2

Section J1 Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

Section J2 Additional MassHealth (Medicaid) appeals

You also have other appeal rights if your appeal is about services or items that MassHealth (Medicaid) usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

Section J3 Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be right for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

Section K How to make a complaint

Section K1 What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and Member Services. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone did not respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you're being pushed out of our plan.
Accessibility and language assistance	• You can't physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider doesn't give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office isn't clean.

Complaint	Example
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call **1-888-867-5511**.

The legal term for a "complaint" is a "**grievance**."

The legal term for "making a complaint" is "**filing a grievance**."

Section K2 Internal complaints

To make an internal complaint, call Member Services at **1-888-867-5511**. You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there's anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.

The legal term for "fast complaint" is "**expedited grievance**."

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

Section K3 External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/my/medicare-complaint. You don't need to file a complaint with UHC Senior Care Options before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. The call is free.

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

U.S. Department of Health and Human Services
Government Center
J.F.Kennedy Federal Building - Room 1875
Boston, MA 02203

Customer Response Center: (800) 368-1019

Fax: (202) 619-3818

TDD: (800) 537-7697

Email: ocrmail@hhs.gov

You may also have rights under the Americans with Disability Act (ADA). You can contact My Ombudsman for assistance by calling 1-855-781-9898 (or using MassRelay at 711 to call 1-855-781-9898 or Videophone (VP) 339-224-6831) or emailing info@myombudsman.org.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to Section H2 or refer to **Chapter 2** of this **Member Handbook**.

In Massachusetts, the QIO is called Acentra Health. The phone number for Acentra Health is 1-888-319-8452.

Chapter 10

Ending your membership in our plan

Chapter 10

Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and MassHealth (Medicaid) programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

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Section A When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you also have MassHealth (Medicaid), you can end your membership with our plan at any time, in any month of the year.

In addition to this flexibility, you may end your membership in our plan during the following periods each year:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for MassHealth (Medicaid) or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- MassHealth (Medicaid) services in **Section C2**.

You can get more information about how you can end your membership by calling: **1-888-867-5511** (TTY users call **711**) Member Services at the number at the bottom of this page. The number for TTY users is listed too.

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP), SHINE at 1-800-243-4636. TTY users (people who are deaf, hard of hearing, or speech disabled) may call 1-800-439-2370.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of this **Member Handbook** for information about drug management programs.

Section B How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 203.
- **Section C** below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

Section C How to get Medicare and MassHealth (Medicaid) services separately

You have choices about getting your Medicare and MassHealth (Medicaid) services if you choose to leave our plan.

Section C1 Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	Here is what to do:
Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE).	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 to enroll in a new integrated D-SNP. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-800-841-2900. If you need help or more information: • Call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users may call 1-800-439-2370. You'll automatically be disenrolled from our plan when your new plan's coverage begins.
2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare drug plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 to enroll in Original Medicare with a separate Medicare drug plan. If you need help or more information: • Call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users should call 1-800-439-2370. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

3. You can change to:	Here is what to do:
Original Medicare without a separate Medicare drug plan **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the SHINE at 1-800-243-4636, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local SHIP office in your area, please visit http://www.mass.gov/elders/healthcare/shine/serving-the-healthinformation-needs-of-elders.html.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 to enroll in Original Medicare. If you need help or more information: • Call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users should call 1-800-439-2370. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

4. You can change to:	Here is what to do:
Any Medicare health plan during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 to enroll in a new Medicare plan. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-800-841-2900.If you need help or more information: • Call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users should call 1-800-439-2370. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.

Section C2 Your MassHealth (Medicaid) services

Some people who decide not to join a Senior Care Options (SCO) plan may be able to join a different kind of plan to get their Medicare and MassHealth (Medicaid) benefits together.

- If you're age 55 or older, you may be eligible to enroll in the Program of All-Inclusive Care for the Elderly (PACE) (additional criteria apply). PACE helps older adults stay in the community instead of getting nursing facility care.

To find out about PACE plans and whether you can join one, call the SHINE Program (Serving Health Insurance Needs of Everyone) at 1-800-243-4636. TTY users should call 1-800-439-2370. Keep getting your Medicare and MassHealth (Medicaid) services and drugs through our plan until your membership ends.

Section D Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and MassHealth (Medicaid) coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your membership in UHC Senior Care Options (HMO D-SNP) ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

Section E Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for MassHealth (Medicaid) and your deeming period has ended. Our plan is for people who qualify for both Medicare and MassHealth (Medicaid).
- If you join a MassHealth Home and Community Based Services (HCBS) Waiver program.
- If you move out of our service area.
- If you move into an Intermediate Care Facility operated by the Massachusetts Department of Developmental Services.
- If you're away from our service area for more than six months.
  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs.
- If you have or get other comprehensive insurance for drugs or medical care.
- If you're not a United States citizen or aren't lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.

– We must disenroll you if you don't meet this requirement.

If you are within our plan's 60 day period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, your MassHealth (Medicaid) coverage may end sooner than your Medicare coverage with us. When your MassHealth (Medicaid) coverage ends, we will not pay for your MassHealth (Medicaid) benefits including the Medicare cost sharing. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.

We will assist your efforts to regain your (MassHealth) Medicaid eligibility. If your MassHealth (Medicaid) eligibility is restored while you are still enrolled with us for your Medicare coverage, we will resume paying for your MassHealth (Medicaid) benefits and your enrollment with us will continue. If you regain MassHealth (Medicaid) eligibility after we disenroll you from our Medicare coverage you will need to reach out to reenroll with us.

We can make you leave our plan for the following reasons only if we get permission from Medicare and MassHealth (Medicaid) first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

Section F Rules against asking you to leave our plan for any health-related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1 800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Section G Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this **Member Handbook** for information about how to make a complaint.

Section H How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

Chapter 11

Legal notices

Chapter 11

Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook.**

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Section A Notice about laws

Many laws apply to this **Member Handbook**. These laws may affect your rights and responsibilities even if the laws aren't included or explained in this **Member Handbook**. The main laws that apply are federal laws about the Medicare and MassHealth (Medicaid) programs. Other federal and state laws may apply too.

Section B Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, age, behavioral or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights
- If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section C Notice about Medicare as a second payer and MassHealth (Medicaid) as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that MassHealth (Medicaid) is the payer of last resort.

Section D Third party liability and subrogation

If you suffer an illness or injury for which any third party is alleged to be liable or responsible due to any negligent or intentional act or omission causing illness or injury to you, you must promptly notify us of the illness or injury. We will send you a statement of the amounts we paid for services provided in connection with the illness or injury. If you recover any sums from any third party, we shall be reimbursed out of any such recovery from any third party for the payments we made on your behalf, subject to the limitations in the following paragraphs.

1. **Our payments are less than the recovery amount.** If our payments are less than the total recovery amount from any third party (the "recovery amount"), then our reimbursement is computed as follows:
   a. **First:** Determine the ratio of the procurement costs to the recovery amount (the term "procurement costs" means the attorney fees and expenses incurred in obtaining a settlement or judgment).
   b. **Second:** Apply the ratio calculated above to our payment. The result is our share of procurement costs.
   c. **Third:** Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.
2. **Our payments equal or exceed the recovery amount.** If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.
3. **We incur procurement costs because of opposition to our reimbursement.** If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
   a. Our payments made on your behalf for services; or
   b. the recovery amount, minus the party's total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment or verdict. You may be required by us and you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

Section E Member liability

In the event we fail to reimburse network a provider's charges for covered services, you will not be liable for any sums owed by us. Neither the plan nor Medicare will pay for those services.

If you enter into a private contract with a provider, neither the plan nor Medicare will pay for those services.

Section F Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your plan, unless otherwise listed as a covered service. A service is "reasonable and necessary" if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
  2. Furnished in a setting appropriate to the patient's medical needs and condition;
  3. Ordered and furnished by qualified personnel;
  4. One that meets, but does not exceed, the patient's medical need; and
  5. At least as beneficial as an existing and available medically appropriate alternative.

Section G Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership.**

Section H Acts beyond our control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, network providers may become unavailable to arrange or provide health services pursuant to this Member Handbook and Disclosure Information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any network provider shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

Section I Contracting medical providers and network hospitals are independent contractors

The relationships between the plan and network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of the plan. An agent would be anyone authorized to act on the plan's behalf.

Section J Technology assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual member, one of our Medical Directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

Section K Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered services under this Member Handbook or be used in defense of a legal action unless it is contained in a written application.

Section L Information upon request

As a plan member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals
- The financial condition of UnitedHealthcare Insurance Company or one of its affiliates

Section M 2026 Enrollee Fraud & Abuse Communication

2026 Enrollee Fraud & Abuse Communication

How you can fight healthcare fraud

Our company is committed to preventing fraud, waste, and abuse in Medicare benefit programs and we're asking for your help. If you identify a potential case of fraud, please report it to us immediately.

Here are some examples of potential Medicare fraud cases:

- A health care provider - such as a physician, pharmacy, or medical device company - bills for services you never got;
- A supplier bills for equipment different from what you got;
- Someone uses another person's Medicare card to get medical care, prescriptions, supplies or equipment;
- Someone bills for home medical equipment after it has been returned;
- A company offers a Medicare drug or health plan that hasn't been approved by Medicare; or
- A company uses false information to mislead you into joining a Medicare drug or health plan.

To report a potential case of fraud in a Medicare benefit program, call UHC Senior Care Options MA-Y001 (HMO D-SNP) Member Services at **1-888-867-5511** (TTY **711**), 8 a.m.-8 p.m.: 7 Days Oct- Mar; M-F Apr-Sept.

This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization will not take any action against you for reporting a potential fraud case in good faith.

You may also report potential medical or prescription drug fraud cases to the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SafeRx (1-877-772-3379) or to the Medicare program directly at (1-800-633-4227). The Medicare fax number is 1-717-975-4442 and the website is medicare.gov.

Section N Commitment of Coverage Decisions

UnitedHealthcare's Clinical Services Staff and Physicians make decisions on the health care services you receive based on the appropriateness of care and service and existence of coverage. Clinical Staff and Physicians making these decisions: 1. Do not specifically receive reward for issuing non-coverage (denial) decisions; 2. Do not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services; and 3. Do not hire, promote, or terminate physicians or other individuals based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Section O Fitness program Terms and Conditions

Renew Active Plan Year 2026 Disclaimers

The Renew Active® Program and its gym network varies by plan/area and may not be available on all plans. Participation in the Renew Active program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership at participating locations and other offerings. The participating locations and offerings may change at any time. Fitness membership equipment, classes and activities may vary by location. Certain services, classes, activities and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services is subject to your acceptance of their respective terms and policies. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor.

Eligibility Requirements

Only members enrolled in a participating Medicare Plan offered by UnitedHealthcare Insurance Company ("UnitedHealthcare") and affiliates are eligible for the fitness program ("Program"), which

includes, without limitation, access to standard fitness memberships at participating gyms/fitness locations, online fitness, cognitive providers and in-person and virtual classes and activities at no additional cost. By enrolling in the Program, you hereby accept and agree to be bound by these Terms and Conditions.

Enrollment Requirements

Membership and participation in the Program is voluntary. You must enroll in the Program according to the information provided on the member site or Member Services. Once enrolled, you must obtain your confirmation code and provide it when requested to sign up for any Program services. Provide your confirmation code when requested when visiting a participating gym/fitness location to receive standard membership access at no additional cost, registering with an online fitness and/or cognitive providers and to gain access to classes and activities. Please note, that by using your confirmation code, you are electing to disclose that you are a Renew Active member with a participating UnitedHealthcare Medicare plan. Program enrollment is on an individual basis and the Program's waived monthly membership rate for standard membership services at participating gyms and fitness locations is only applicable to individual memberships.

You are responsible for any and all non-covered services and/or similar fee-based products and services offered by Program service providers (including, without limitation, gym/fitness centers, digital fitness offerings, digital cognitive providers and other third party service offerings made available through the Program), including, without limitation, fees associated with personal training sessions, specialized classes and enhanced facility membership levels beyond the standard membership level. No reimbursements will be made for any fitness program offerings. Fitness membership offerings, including visits, hours, equipment, classes, personalized fitness plans, caregiver access and activities, can vary by location. Access to gym and fitness location network varies by plan/area and may not be available on all plans.

Community Resources, Classes and Activities Disclaimer

Information about classes and activities in your area is being made available so you will have an opportunity to learn about some community resources that may help your overall health and well-being. This information is provided solely as a convenience, and participation is voluntary. While the resources mentioned herein are at no additional cost, please note that charges may apply for other programs, classes, activities or services listed on a third-party website or otherwise offered by such third party. UnitedHealthcare does not endorse third-party organizations providing classes and activities and is not responsible for the information, products or services these organizations provide or the content on any linked site or any link contained in a linked site. These resources are not meant to replace professional health care and should not be used for emergency or urgent care needs. If you have health concerns, or before starting a new workout or diet program, please talk with your doctor. You and your health care provider must ultimately determine if you want to participate in these classes and activities. Be mindful that, if a resource is being offered on the internet, internet forums may contain misinformation.

Liability Waiver

Always seek the advice of a doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine.

Certain services, classes, activities and online fitness offerings are provided by affiliates of UnitedHealthcare or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services is subject to your acceptance of their respective terms and policies.

UnitedHealthcare and its respective subsidiaries are not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor.

UnitedHealthcare and its respective subsidiaries and affiliates do not endorse and are not responsible for the services or information provided by third parties, the content on any linked site, or for any injuries you may sustain while participating in any services, classes, activities and online fitness offerings under the Program.

Other Requirements

You must verify that the individual gym/fitness location or service provider participates in the Program before enrolling. If a Program service provider you use, including a gym or fitness location, ceases to participate in the Program, your Program participation and waived monthly membership rate with such service provider through the Program will be discontinued until you join another service offered by a participating service provider. You will be responsible for paying the standard membership rates of the such service provider should you elect to continue to receive services from a service provider once that service provider ceases to participate in our Program. If you wish to cancel your membership with such service provider, you can opt to do so per the cancellation policy of the applicable service provider, including the applicable gym or fitness location. You should review your termination rights with a service provider when you initially elect to sign up with such service provider.

Data Requirements

The Program administrator and/or your service provider will collect and electronically send and/or receive the minimum amount of your personal information required in order to facilitate the Program in accordance with the requirements of applicable laws, including privacy laws. Such required personal information includes, but is not limited to, program confirmation code, gym/fitness location/provider membership ID, activity year and month, and monthly visit count. By enrolling in the Program, you authorize the Program administrator and your service provider to request and/or provide such personal information.

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Optum Financial®

Privacy notice

Rev. 08/2025

Facts	What does Optum Bank do with your personal information?
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Medicare Beneficiary Identifier or Member Identification Number and account balances • Payment history and transaction history • Purchase history and account transactions When you are no longer our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share members' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their members' personal information, the reasons Optum Bank chooses to share and whether you can limit this sharing.

Reasons we can share your personal information	Does Optum Bank share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – information about your transactions and experiences, which is not used by affiliates to market their products to you	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?	**Please call 1-866-234-8913 or visit us online at optumbank.com.**

What we do	
How does **Optum Bank** protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We also have additional safeguards to protect your information and we limit who can access it.
How does **Optum Bank** collect my personal information?	We collect your personal information, for example, when you: • Use your payment card or pay a bill • Update your contact information We also collect your personal information from others, such as affiliates or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only: • Sharing for affiliates' everyday business purposes – information about your creditworthiness • Affiliates from using your information to market to you • Sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. • Our affiliates include companies within UnitedHealth Group and those companies that share the Optum name; financial companies such as Optum Financial, Inc. and UnitedHealthcare Insurance Company; and nonfinancial companies such as UHG Print Services.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • Optum Bank does not share with nonaffiliates so they can market to you.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • Optum Bank does not engage in any joint marketing.

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Chapter 12

Definitions of important words

Chapter 12

Definitions of important words

Introduction

This chapter includes key terms used throughout this **Member Handbook** with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this **Member Handbook** explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Biological Product: A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (See also "Original Biological Product" and "Biosimilar").

Biosimilar: A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (Go to "Interchangeable Biosimilar").

Brand name drug: A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

Care manager: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized Care Plan."

Care team: Refer to "Interdisciplinary Care Team."

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of this **Member Handbook** explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Cost-Sharing: Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of this **Member Handbook** explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and MassHealth (Medicaid). Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded Services: Services that aren't covered by this health plan.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy", or "LIS".

Generic drug: A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Managers to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.

- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Services if you get any bills you don't understand.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.

Individualized Care Plan (ICP or Care Plan): A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all MassHealth (Medicaid) services under a single health plan for certain groups of individuals eligible for both Medicare and MassHealth (Medicaid). These individuals are known as full-benefit dually eligible individuals.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (Drug List): A list of prescription and over the counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The **Drug List** tells you if there are any rules you need to follow to get your drugs. The **Drug List** is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help"

MassHealth (Medicaid): The MassHealth (Medicaid) program of the Commonwealth of Massachusetts. MassHealth (Medicaid) is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- MassHealth (Medicaid) programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and MassHealth (Medicaid).

MassHealth (Medicaid) (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage: A Medicare program, also known as "Medicare Part C" or "MA", that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-MassHealth (Medicaid) enrollee: A person who qualifies for Medicare and MassHealth (Medicaid) coverage. Medicare-MassHealth (Medicaid) enrollee is also called a "dually eligible individual".

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as "Medicare Advantage" or "MA", that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or MassHealth (Medicaid). Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. MassHealth (Medicaid) may cover some of these drugs.

Medication Therapy Management (MTM): A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to **Chapter 5** of this **Member Handbook** for more information.

Member (member of our plan, or plan member): A person with Medicare and MassHealth (Medicaid) who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Handbook and Disclosure Information: This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this **Member Handbook** for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They're licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and don't charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services.

Network providers are also called “plan providers”.

Nursing home or facility: A place that provides care for people who can’t get their care at home but don’t need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson’s services are free. You can find more information in **Chapters 2 and 9** of this **Member Handbook**.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions”. **Chapter 9** of this **Member Handbook** explains coverage decisions.

Original Biological Product: A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It’s also called a reference product.

Original Medicare (Traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don’t want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that hasn’t agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn’t cover most drugs you get from out of network pharmacies unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that isn’t employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. **Chapter 3** of this **Member Handbook** explains out-of-network providers or facilities.

Out-of-pocket costs: The cost- sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost-sharing” above.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to “Medicare Part A.”

Part B: Refer to “Medicare Part B.”

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Preventive services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this **Member Handbook** for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this **Member Handbook**.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the **List of Covered Drugs** and the rules are posted on our website.

Program of All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and MassHealth (Medicaid) benefits together for people age 55 and over who need a higher level of care to live at home.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this **Member Handbook** for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this **Member Handbook**.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of this **Member Handbook** to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Hearing: If your doctor or other provider asks for a MassHealth (Medicaid) service that we won't approve, or we won't continue to pay for a MassHealth (Medicaid) service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to obtain services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).

Member Services:

myuhc.com/CommunityPlan

Call **1-888-867-5511**
Calls to this number are free.
8 a.m.–8 p.m. local time, 7 days a week.
Member Services also has free language interpreter services available for non-English speakers.

TTY **711**
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Calls to this number are free. 8 a.m.–8 p.m. local time, 7 days a week.

Write: **UnitedHealthcare Community Plan**
P.O. Box 30770
Salt Lake City, UT 84130-0770

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

You can call the SHIP in your state at the number listed in Chapter 2 of the Member Handbook.

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