Evidence of Coverage for 2026

UHC Dual Complete TN-Y001 (HMO-POS D-SNP)

MyUHC.com/CommunityPlan

Toll-free **1-800-690-1606**, TTY **711**
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United Healthcare®

Y0066_EOC_H0251_004_000_2026_C

January 1–December 31, 2026

Evidence of Coverage

Your Health and Drug Coverage under UHC Dual Complete TN-Y001 (HMO-POS D-SNP)

Evidence of Coverage Introduction

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

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

When this **Evidence of Coverage** says “we”, “us”, “our”, or “our plan”, it means UHC Dual Complete TN-Y001 (HMO-POS D-SNP).

This document is available for free in Spanish and Arabic.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al **1-800-690-1606**, para obtener información adicional (los usuarios de TTY deben llamar al **711**). El horario es 8 a.m. a 8 p.m.: los 7 días de la semana, de octubre a marzo; de lunes a viernes, de abril a septiembre.

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

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at 1-800-690-1606. Someone that speaks your language can help you. This is a free service. UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al **1-800-690-1606**, para obtener información adicional (los usuarios de TTY deben llamar al **711**). El horario es 8 a.m. a 8 p.m.: los 7 días de la semana, de octubre a marzo; de lunes a viernes, de abril a septiembre.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2027. 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.

This document explains your benefits and rights. Use this document to understand about:

- Our plan premium
- Our medical and drug benefits
- How to file a complaint if you are not satisfied with a service or treatment from a provider or pharmacy

- How to contact us
- Other protections required by Medicare law

Do you need free help with this letter?

If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: **Español**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-690-1606 (TRS: 711).

Kurdish: کوردی

ئاگادارى: ئەگەر بە زمانى كوردى قسە دەكەيت، خزمەتگوزارىيەكانى يارمەتى زمان، بەخۆڕايى، بۆ تۆ بەردەستە. پەيوەندى بە **1-800-690-1606** (TRS:**711**). بكە.

Arabic: العربية

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم **1-800-690-1606**(TRS:**711**).)

Chinese: **繁體中文**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-690-1606 (TRS: 711).

Vietnamese: **Tiếng Việt**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-690-1606 (TRS: 711).

Korean: **한국어**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-690-1606 (TRS: 711).번으로 전화해 주십시오.

French: **Français**

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-690-1606 (TRS: 711).

Amharic: **አማርኛ**

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-690-1606 (መስማት ለተሳናቸው:TRS: 711).

Gujarati: **ગુજરાતી**

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-690-1606 (TRS: 711) .

Laotian: **ພາສາລາວ**

ໂປດຊາບ: ຖ້າ ອ່າ ທ່ານ ເວົ້າ ພາ ສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ວຍ ເຫຼືອ ດ້ານ ພາ ສາ, ໂດຍບໍ່ ເສັຽ ຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ ທ່ານ. ໂທ ຣ 1-800-690-1606 (TRS: 711).

German: **Deutsch**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-690-1606 (TRS: 711).

Tagalog: **Tagalog**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-690-1606 (TRS: 711).

Hindi: **हिंदी**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।1-800-690-1606 (TRS: 711) . पर कॉल करें।

Serbo-Croatian: **Srpsko-hrvatski**

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno.

Nazovite 1-800-690-16065 (TRS-Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Russian: **Русский**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-690-1606 (телетайп: TRS:711).

Nepali: **नेपाली**

ध्यान दिनुहोस्: तपाइंले नेपाली बोल्नुहुन्छ भने तपाइंको निमित्त भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-690-1606 (टिटिवाइ: TRS: 711)

Persian: **فارسی**

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-690-1606 (TRS: 711) تماس بگیرید.

- Do you need help talking with us or reading what we send you?
- Do you have a disability and need help getting care or taking part in one of our programs or services?
- Or do you have more questions about your health care?

Call us for free at **1-800-690-1606**. We can connect you with the free help or service you need. (For TRS call **711**.)

We obey federal and state civil rights laws. We don't treat people in a different way because of their race, color, birthplace, language, age, disability, religion, or sex. Do you think we didn't help you or you were treated differently because of your race, color, birthplace, language, age, disability, religion, or sex? You can file a complaint by mail, by email, or by phone. Here are three places where you can file a complaint:

TennCare Office of Civil Rights Compliance

310 Great Circle Road, 3W, Nashville, Tennessee 37243

Email: HCFA.Fairtreatment@tn.gov Phone: 1-855-857-1673 (TRS 711)

You can get a complaint form online at:
tn.gov/content/dam/tn/tenncare/documents/complaintform.pdf

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

Email: **UHC_Civil_Rights@uhc.com** Phone: **1-800-690-1606**

U.S. Department of Health & Human Services, Office for Civil Rights

200 Independence Ave SW, Rm 509F, HHH Bldg., Washington, DC 20201

Phone: 1-800-368-1019 (TDD): 1-800-537-7697

You can file a complaint online at: ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Disclaimers

- Benefits may change on January 1, 2027.
- Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.
- 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.
- Every year, Medicare evaluates plans based on a 5-star rating system.
- Notice: TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits. Any additional Medicare benefit mentioned in this communication above Original Medicare is applicable to the Medicare benefit only and does not indicate increased Medicaid benefits.
- Benefits, features and/or devices may vary by plan/area. Limitations, exclusions and/or network restrictions may apply.

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

2026 Evidence of Coverage
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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 Dual Complete TN-Y001 (HMO-POS D-SNP), a health plan that coordinates all of your Medicare and TennCare 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 **Evidence of Coverage**.

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A. Welcome to our plan

Our plan provides Medicare and TennCare services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.

B. Information about Medicare and TennCare

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).

B2. TennCare

TennCare is the name of Tennessee's Medicaid program. TennCare is run by the state and is paid for by the state and the federal government. TennCare 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 state of Tennessee approved our plan. You can get Medicare and TennCare services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of Tennessee allow us to continue to offer this plan.

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

C. Advantages of our plan

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

We help make your Medicare and TennCare 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 coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator 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.

New members to UHC Dual Complete TN-Y001 (HMO-POS D-SNP): In most instances you'll be enrolled in UHC Dual Complete TN-Y001 (HMO-POS D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in UHC Dual Complete TN-Y001 (HMO-POS D-SNP). You may still receive your TennCare from your previous TennCare health plan for one additional month. After that, you'll receive your TennCare services through UHC Dual Complete TN-Y001 (HMO-POS D-SNP). There will be no gap in your TennCare coverage. Please call us at the number at the bottom of the page if you have any questions.

D. Our plan's service area

Our service area includes these counties in Tennessee: Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Carter, Cheatham, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Monroe, Montgomery, Moore, Morgan, Obion, Overton,

Perry, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Wayne, Weakley, White, Williamson, Wilson. 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 **Evidence of Coverage** for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

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

- 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 TennCare **and**
- are eligible for Long Term Care CHOICES benefits in groups 1, 2, or 3.

If you lose eligibility but can be expected to regain it within 90 days then you're still eligible for our plan.

Call Customer Service for more information.

F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.

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, telephone call, or mail.

We'll send you more information about this HRA.

You may continue to see your previous provider or receive previous services for at least 30 days to ensure continuity of care pending the provider enrolling under the health plan or finding a new provider under the health plan to facilitate a seamless transition of those services.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, or other health person that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator 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 coordinator and care team.

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 LTSS services using a person-centered approach to your needs assessment and care planning.

Your care plan includes:

- your health care goals, **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. Your care team works with you to update your care plan at least every year.

H. Summary of important costs

H1. Plan premium

Our plan has no premium.

H2. Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

As a member of UHC Dual Complete TN-Y001 (HMO-POS D-SNP) you receive up to a $0.70 reduction of your monthly Medicare Part B premium. The reduction is set up by Medicare and administered through the Social Security Administration (SSA). Rebates apply only to amounts

you pay toward the Medicare Part B premium and are not issued on any premium amount paid by Medicaid. Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement.

Reductions may take several months to be issued; however, you will receive a full credit for amounts you have paid.

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 Medicaid as well as have both Medicare Part A and Medicare Part B. For most UHC Dual Complete TN-Y001 (HMO-POS D-SNP) **members**, Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and Part B premium.

If 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. You may also pay a premium for Medicare Part A if you aren't eligible for premium-free Medicare Part A. **In addition, please contact Customer Service or your care coordinator and inform them of this change.**

H3. Income Related Monthly Adjustment Amount

If you lose eligibility for this plan because of changes in income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit Medicare.gov/health-drug-plans/part-d/basics/costs.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay our plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. **If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out more about how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

H4. Medicare Prescription Payment Amount

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from your plan for your drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 9** to make a complaint or appeal.

I. This Evidence of Coverage

This **Evidence of Coverage** 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 **Evidence of Coverage** or call 1-800-MEDICARE (1-800-633-4227).

You can ask for an **Evidence of Coverage** by calling Customer Service at the numbers at the bottom of the page. You can also refer to the **Evidence of Coverage** found on our website at the web address at the bottom of the page.

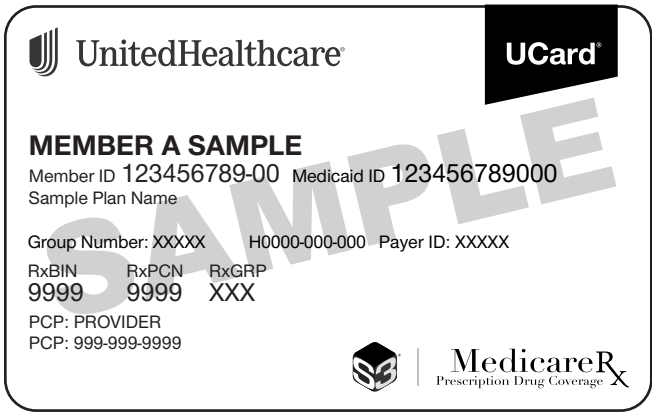
The contract is in effect for the months you're enrolled in our plan between January 1st, 2026 and December 31st, 2026.

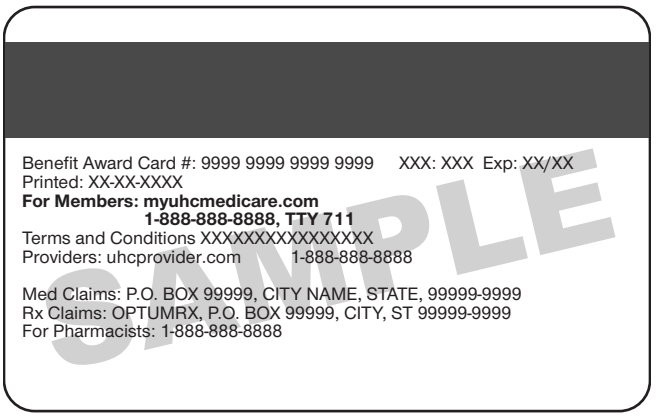
J. Other important information you get from us

Other important information we provide to you includes your UnitedHealthcare 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**.

J1. Your UnitedHealthcare UCard®

Under our plan, you have one card for your Medicare and TennCare 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 Customer Service at the number at the bottom of the page right away. We'll send you a new UCard.

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 TennCare 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 UnitedHealthcare 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 your **Evidence of Coverage** to find out what to do if you get a bill from a provider.

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 Customer Service 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.

This directory may also identify which providers participate in TennCare (Medicaid). You may see any provider in the directory for plan covered services, even if they do not participate in TennCare (Medicaid). Please contact TennCare (Medicaid) for more information on participating TennCare (Medicaid) providers.

When first enrolled or when there's a change to your provider, you can continue to receive your service or TennCare for at least 30 days.

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**
- LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or TennCare.

Network providers agree to accept payment from our plan for covered services as payment in full.

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 pay for them.

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

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 prescription 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, Section B3**. Medicare approved the UHC Dual Complete TN-Y001 (HMO-POS 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 **Evidence of Coverage** for more information.

Each year, we send you 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 Customer Service or visit our website at the address at the bottom of the page.

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 such as increases in price and other drugs with lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options. **Chapter 6** of this Evidence of Coverage 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 Customer Service at the numbers at the bottom of the page.

K. Keeping 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 Customer Service at the numbers at the bottom of the page.

TennCare Connect is an online tool for Tennesseans to apply and manage their TennCare benefits. You can access the website: tenncareconnect.tn.gov or call TennCare customer service at 1-855-259-0701.

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 **Evidence of Coverage**.

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 coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of this **Evidence of Coverage**.

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A. Customer Service

Method	Contact information
Call	**1-800-690-1606**. This call is free. Available 8am–8pm: 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. Available 8am–8pm: 7 Days Oct–Mar; M–F Apr–Sept.
Write	UnitedHealthcare Customer Service Department P.O. Box 30769 Salt Lake City, UT 84130-0769
Website	**MyUHC.com/CommunityPlan**

Contact Customer Service 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 **Evidence of Coverage**.
- 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 **Evidence of Coverage** or contact Customer Service.
- 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 D**).

- You can call us and explain your complaint at **1-800-690-1606**.
- 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 medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- File a complaint with TennCare at 1-800-878-3192 or 1-866-771-7043 TTY.
- To learn more about making a complaint about your health care, refer to **Chapter 9** of this **Evidence of Coverage**.

• 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 and your TennCare CoverRX benefits.
- For more on coverage decisions about your drugs, refer to **Chapter 9** of this **Evidence of Coverage**.

• 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 **Evidence of Coverage**.

• 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 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 prescription drugs, refer to **Chapter 9** of this **Evidence of Coverage**.

• 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 **Evidence of Coverage**.

Method	Contact information
Call	**1-800-690-1606** This call is free. Available 8 a.m.–8 p.m.: 7 days Oct–Mar; M–F Apr–Sept. **For fast/expedited appeals for medical care:** 1-855-409-7041 Calls to this number are free. Hours of Operation: 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept We have free interpreter services for people who do not 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.
Fax	For fast/expedited appeals only: 1-866-373-1081
Write	For complaints/grievances or medical appeals: UnitedHealthcare Appeals and Grievance Department P.O. Box 6103 MS CA 120-0360 Cypress, CA 90630-0023 For Part D or Medicaid drug appeals only: UnitedHealthcare Part D Appeals and Grievance Department P.O. Box 6103 MS CA 120-0368 Cypress, CA 90630-0023
Website	**MyUHC.com/CommunityPlan**

– 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 **Evidence of Coverage**.

B. Your Care Coordinator

A Care Coordinator 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 Coordinator and an initial health screen. If additional needs are identified, a referral for a comprehensive needs assessment with a clinical Care Coordinator 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 Coordinator assigned.

Method	Contact information
Call	**1-800-690-1606**. This call is free. Hours of Operation: 8 a.m.–8p.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. Hours of Operation: 8 a.m.–8p.m.: 7 days Oct–Mar; M–F Apr–Sept
Write	UnitedHealthcare Customer Service Department P.O. Box 30769, Salt Lake City, UT 84130-0769
Website	**MyUHC.com/CommunityPlan**

Contact your care coordinator to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about transportation
- information about CHOICES and answer your questions to help you get the right kind of long-term services and supports in the right setting for you to address your needs including:
  - Coordinate all of your physical health, behavioral health (mental health or substance use disorder) and long-term services and supports needs.
  - Help to fix problems and answer questions that you have about your care.
  - Check at least once a year to make sure that you continue to need the level of care provided in a nursing home or, for Group 3, continue to be "at risk" of going into a nursing home.

  - Communicate with your providers to make sure they know what's happening with your health care and to coordinate your service delivery.
- Other tasks performed by the Care Coordinator will vary slightly depending on the CHOICES Group you're enrolled in. **If you receive nursing home care in CHOICES Group 1, your Care Coordinator will:**
  - Be part of the care planning process with the nursing home where you live.
  - Perform any additional needs assessment that may be helpful in managing your health and long-term services and supports needs.
  - Supplement (or add to) the nursing home's plan of care if there are things the managed care organization or "MCO" can do to help manage health problems or coordinate other kinds of physical and behavioral health (mental health or substance use disorder) care you need.
  - Conduct face-to-face visits at least every 6 months.
  - Coordinate with the nursing home when you need services the nursing home isn't responsible for providing.
  - Determine if you're interested and able to move from the nursing home to the community and if so, help make sure this happens timely.
- **If you receive home care in CHOICES Group 2 or Group 3, your Care Coordinator will work with you to:**
  - Do a comprehensive, individual assessment of your health and long-term services and supports needs; and
  - Develop a **Person-Centered Support Plan**.
- **Your Care Coordinator will also:**
  - Make sure your plan of care is carried out and working the way that it needs to.
  - Monitor to make sure you're getting what you need and that gaps in care are addressed right away.
  - Contact you by telephone at least once every month and visit you in person at least once every 3 months if you're in Group 2 or contact you by telephone at least once every 3 months and visit you in person at least once every 6 months if you're in Group 3. These visits may occur more often if you get residential services or based on your needs.
  - Make sure the home care services you receive are based on your goals, needs and preferences and don't cost more than nursing home care, if you're in Group 2, or more than $18,000 if you're in Group 3.

C. TN SHIP (TN State Health Insurance Assistance Program)

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 Tennessee the SHIP is called TN SHIP.

TN SHIP 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	Contact information
Call	1-877-801-0044 8:00am – 4:30pm CST
TTY	1-800-848-0299
Write	502 Deaderick Street, 9th Floor Nashville, TN 37243-0860
Email	tn.ship@tn.gov
Website	tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html

Contact TN SHIP for help with:

- questions about Medicare
- TN SHIP 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.

D. Quality Improvement Organization (QIO)

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

Method	Contact information
Call	Members: 1-888-317-0751 Fax: 1-844-878-7921
Write	ACENTRA 5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609
Website	acentraqio.com

Contact ACENTRA 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.

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 & Medicaid Services, or CMS. This agency contracts with Medicare Advantage organizations including our plan.

Method	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	Chat live at www.Medicare.gov/talk-to-someone
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	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 medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program

F. TennCare

TennCare helps with medical and long-term services and supports costs for people with limited incomes and resources.

You're enrolled in Medicare and in TennCare. If you have questions about the help you get from Medicaid, call TennCare.

Method	Contact information
Call	TennCare at 1-855-259-0701 8:00am – 4:30pm CST
TTY	1-800-848-0299
Write	310 Great Circle Rd. Nashville, TN 37243
Email	tenn.care@tn.gov
Website	tn.gov/tenncare

G. Tennessee State Long-Term Care (LTC) Ombudsman

The Tennessee State LTC Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Tennessee State LTC Ombudsman program offers assistance to persons living in nursing homes or other community-based residential settings, like an assisted living or critical adult care home. A Long-Term Care Ombudsman **doesn't** work for the facility, the state, or MCO. This helps them to be fair and objective in resolving problems and concerns.

The Long-Term Care Ombudsman in each area of the state can:

- Provide information about admission to and discharge from long-term services and supports facilities.
- Provide education about resident rights and responsibilities.
- Help residents and their families resolve questions or problems they have been unable to address on their own with the facility. Concerns can include things like:
  - quality of care;
  - resident rights; or
  - admissions, transfers, and discharges

To find out more about the Long-Term Care Ombudsman program, or to contact the Ombudsman in your area, call the Tennessee Commission on Aging and Disability.

Method	Contact information
Call	Tel: 615-253-5412 Fax: 615-741-3309 Toll Free: 877-236-0013 8:00am – 4:30pm CST
TTY	Toll Free: 1-800-848-0299 615-532-3893
Write	502 Deaderick Street, 9th Floor Nashville, TN 37243-0860
Email	ombudsman.notification@tn.gov
Website	tn.gov/disability-and-aging/disability-aging-programs/long-term-care-ombudsman.html

H. Programs to Help People Pay for Drugs

The Medicare.gov website (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.

H1. Extra Help from Medicare

Because you're eligible for TennCare, 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	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	medicare.gov

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help get evidence of your correct copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- Fax the information to 501-262-7070 or mail it to P.O. Box 29300, Hot Springs, AR 71903-9300.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Customer Service at the number at the bottom of the page if you have questions.

H2. State Pharmaceutical Assistance Program (SPAP) — CoverRX

If you're enrolled in a SPAP, or any other program that provides coverage for Medicare Part D drugs other than **Extra Help** you still get the 70 percent discount on covered brand name drugs. Also, the plan pays five percent of the cost of brand drugs in the coverage gap. The 70 percent discount and the five percent paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

H3. AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible people living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the Tennessee Ryan White Part B Program. **Note:** To be eligible for the ADAP operating in your state, people must meet certain criteria, including proof of the state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to receive assistance for information on eligibility criteria, covered drugs, or how to enroll in the program, please call 615-532-6509.

H4. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same plan, you don't need to do anything to continue this option.** Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in this payment option, no matter your income level, and plans with drug coverage must offer this payment option. To learn more about this payment option, call Member Services at the phone number at the bottom of the page or visit Medicare.gov.

I. 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	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	ssa.gov

J. 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, it is important that you let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

Method	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 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	rrb.gov

K. Group insurance or other insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse's or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Service at the number at the bottom of this page with any questions. You can ask about your (or your spouse's or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can also call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse's or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. The benefits administrator can help you understand how your current drug coverage will work with our plan.

Chapter 3

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

Chapter 3

Using our 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 coordinator, 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 **Evidence of Coverage**.

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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 **Evidence of Coverage**. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this **Evidence of Coverage**.

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 which includes cost sharing as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and TennCare. This includes behavioral health and LTSS.

Our plan will generally 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 **Evidence of Coverage**.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your 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 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 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 a referral 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, see to **Section D1** in this chapter).

- **You must get your care from network providers.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you will have to pay the provider in full for the services provided. 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, see **Section I** in this chapter).
  - If you need care from a Specialist that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. You MUST get prior approval for these services. In this situation, we cover the care as if you got it from a network provider at no additional 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. You can get these services at a Medicare-certified dialysis facility.
  - If you were already getting care or treatment when your TennCare started, you may be able to keep getting the care without an approval or referral.

C. Your care coordinator

We're responsible for managing all of your physical health, behavioral health (mental health or substance use disorder) and long-term services and supports needs, and the services that you receive to address these needs. This is called care coordination. We'll assign you a care coordinator when you enroll in our plan.

C1. What's a care coordinator

Your care coordinator will play a very important role. Your care coordinator is your primary contact person and is the first person that you should go to if you have any questions about your services. Your care coordinator will:

- Provide information about your coverage and answer your questions.
- Help you get the right kind of long-term services and supports in the right setting for you to address your needs.
- Coordinate all of your physical health, behavioral health (mental health or substance use disorder) and long-term services and supports needs.
- Help to fix problems and answer questions that you have about your care.
- Check at least once a year to make sure that you continue to need the level of care provided in a nursing home or, for Group 3, continue to be "at risk" of going into a nursing home.

- Communicate with your providers to make sure they know what's happening with your health care and to coordinate your service delivery.

C2. How you can contact your care coordinator

Contact your care coordinator by calling Customer Service at **1-800-690-1606**, TTY **711**.

C3. How you can change your care coordinator

Change your care coordinator by calling Customer Service at **1-800-690-1606**, TTY **711**.

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care.

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

What is a PCP?

A Primary Care Provider (PCP) is a network physician who is selected by you to provide and 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

You must select a PCP from the **Provider and Pharmacy Directory** at the time of your enrollment. You may, however, visit any network provider you choose.

For a copy of the most recent **Provider and Pharmacy Directory**, or for help in selecting a PCP, call Customer Service or visit **MyUHC.com/CommunityPlan** for the most up-to-date information about our network providers. If you do not select a PCP at the time of enrollment, we may pick one for you. You can change your PCP at any time. See "Changing your PCP" below.

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 Customer Service or you can go online. If the PCP is accepting additional plan members, the change will become effective on the first day of the following month.

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 Customer Service 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.
- 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.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.

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.

If the network specialist wants you to come back for more care, please make sure those services will be covered services, by checking first with your PCP to make sure that your referral will extend to the additional care.

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.

Please refer to Chapter 4, Section D for more information about which services require prior authorization.

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 the website listed in Chapter 2 of this booklet.

If you use an out-of-network provider for routine dental services, your share of the costs for your covered services are described in "Covered Routine Dental Benefits" in Chapter 4.

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.

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 change 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 you're getting continues. We'll work with you so you can continue to get care.
- We'll give you information about the available 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 and 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.)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care.

D4. Out-of-network providers

As a member of our plan, you can choose to get care from out-of-network providers for routine dental services only. For more information see the "Covered Routine Dental Benefits" in Chapter 4. **Care that you receive from out-of-network providers will not be covered unless the care meets one of the four exceptions described in Section B of this chapter.** For information about getting out-of-network care when you have a medical emergency or urgent need for care, please see Section I in this chapter. Please call Customer Service for help with how to get care from out-of-network providers.

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

- We can't pay a provider who isn't eligible to participate in Medicare and/or TennCare.
- 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.

E. Long-term services and supports (LTSS)

TennCare CHOICES is Long-Term Services and Supports (or CHOICES for short) for adults (age 21 and older) with a physical disability and seniors (age 65 and older). CHOICES offers services

to help a person live in their own home or in the community. These services are called **Home and Community Based Services** or HCBS. These services can be provided in the home, on the job, or in the community to assist with daily living activities and allow people to work and be actively involved in their local community. CHOICES also provides care in a nursing home if it's needed.

E1. How do I apply for CHOICES?

If you think you need long-term services and supports, call us at **1-800-690-1606**, TTY **711**. We may use a short screening that will be done over the phone to help decide if you may qualify for CHOICES. If the screening shows that you don't appear to qualify for CHOICES, you'll get a letter that says how you can finish applying for CHOICES.

If the screening shows that you might qualify for CHOICES, or if we don't conduct a screening over the phone, we will send a care coordinator to your home to do an assessment.

The purpose of the in-home assessment is to help you apply for CHOICES. It's also to find out:

- The kinds of help you need;
- the kinds of care being provided by family members and other caregivers to help meet your needs; and
- the gaps in care for which paid long-term services and supports may be needed.

If you want to receive care at home or in the community (instead of going to a nursing home), the assessment will help decide if your needs can be safely met in the home or community setting. For CHOICES Group 2 (you can read about all of the CHOICES Groups below), it will help decide if the cost of your care would exceed the cost of nursing home care.

This **doesn't** mean that you'll receive services up to the cost of nursing home care. CHOICES won't pay for more services than you must have to safely meet your needs at home. And CHOICES only pays for services to meet long-term services and supports needs that can't be met in other ways.

CHOICES services provided to you in your home or in the community won't take the place of care you get from family and friends or services you already receive.

If you're getting help from community programs, receive services paid for by Medicare or other insurance, or have a family member that takes care of you, these services won't be replaced by paid care through CHOICES. Instead, the home care you receive through CHOICES will work together with the assistance you already receive to help you stay in your home and community longer. Care in CHOICES will be provided as cost-effectively as possible so that more people who need care will be able to get help.

However, if you've been getting services through the State-funded Options program, you won't qualify to get those services anymore. They're for people who don't get TennCare. And if you've been getting services from programs funded by the Older Americans Act (like Meals on Wheels, homemaker, or the National Caregiver Family Support Programs) that you can now get through CHOICES, you'll get the care you need through CHOICES.

If you want home care, the care coordinator will also assess risk. This will help to identify any additional risks you may face as a result of choosing to receive care at home. It will also help to identify ways to help reduce those risks and to help keep you safe and healthy.

To see if you qualify to enroll in CHOICES, call us at **1-800-690-1606**, TTY **711**.

Does someone you know that isn't on TennCare want to apply for CHOICES? They should contact their local Area Agency on Aging and Disability (AAAD) for free at 866-836-6678. Their local AAAD will help them find out if they qualify for TennCare and CHOICES.

E2. Who can qualify to enroll in CHOICES?

There are (3) groups of people who can qualify to enroll in CHOICES.

CHOICES Group 1 is for people of all ages who receive nursing home care.

To be in CHOICES Group 1, you must:

- Need the level of care provided in a nursing home, **and**
- qualify for TennCare long-term services and supports, **and**
- receive nursing home services that TennCare pays for.

TennCare Long-Term Services and Supports will decide if you need the level of care provided in a nursing home. TennCare Customer Service will decide if you qualify for TennCare long-term services and supports. We'll help you fill out the papers TennCare needs to decide. What if TennCare says yes? If you're receiving nursing home services that TennCare will pay for, TennCare will enroll you into CHOICES Group 1. If TennCare says you don't qualify, you'll get a letter that says why. It will say how to appeal if you think it's a mistake.

CHOICES Group 2 is for certain people who qualify for nursing home care but choose to receive home care instead. To be in CHOICES Group 2, you must:

- Need the level of care provided in a nursing home, **and**
- qualify for TennCare long-term services and supports because you receive SSI payments OR because you'll need and will receive home care services instead of nursing home care, **and**
- be an adult 65 years of age or older, **or**
- be an adult 21 years of age or older with a physical disability.

If you need home care services but don't qualify in one of these groups, you can't be in CHOICES Group 2, but you may qualify for other kinds of long-term services and supports.

TennCare Long-Term Services and Supports will decide if you need the level of care provided in a nursing home. TennCare Customer Service will decide if you qualify for TennCare long-term services and supports for one of the reasons listed above. We'll help you fill out the papers they need to decide. If TennCare says yes, to enroll in CHOICES Group 2 and begin receiving home care services:

- We must be able to safely meet your needs at home.
- And the cost of your home care can't be more than the cost of nursing home care. The cost of your home care includes any home health or private duty nursing care you may need.

If we can't safely meet your needs at home, **or** if your care would cost more than nursing home care, you can't be in CHOICES Group 2. But you may qualify for other kinds of long-term services and supports.

If TennCare says you don't qualify, you'll get a letter that says why. It will say how to appeal if you think it's a mistake.

CHOICES Group 3 is for certain people who **don't qualify for nursing home care** but **need home care** to help them stay at home safely.

To be in CHOICES Group 3, you must:

- Be "at risk" of going into a nursing home unless you receive home care, **and**
- qualify for TennCare long-term services and supports because you receive SSI payments OR because you'll receive home care services instead of nursing home care, **and**
- be an adult 65 years of age or older, **or**
- be an adult 21 years of age or older with a physical disability.

TennCare Long-Term Services and Supports will decide if you're "at risk" of going into a nursing home. TennCare Customer Service will decide if you qualify for TennCare long-term services and supports for one of the reasons listed above. We'll help you fill out the papers they need to decide.

If TennCare says yes, to enroll in CHOICES Group 3 and begin receiving home care services:

- We must be able to safely meet your needs at home with the care you'd get in CHOICES Group 3.
- If we can't safely meet your needs with the care that you'd get in CHOICES Group 3, you can't be in CHOICES Group 3. But TennCare may decide that you qualify for other kinds of long-term services and supports, including nursing home care.

E3. Limits on Enrollment into CHOICES Group 2 and 3

Not everyone who qualifies to enroll in CHOICES Group 2 or Group 3 may be able to enroll. There is an enrollment target for CHOICES Group 2 and Group 3. It's like a limit on the number of people who can be in the group at one time. (The number of people who can enroll is sometimes called "slots".) This helps to ensure that the program doesn't grow faster than the State's money to pay for home care. It also helps to ensure that there are enough home care providers to deliver needed services.

The enrollment target for the number of slots that can be filled in CHOICES Group 2 and Group 3 will be set by the state in TennCare Rules.

For CHOICES Group 2 it doesn't apply to people moving out of a nursing home. And, it **may** not apply to some people who are on TennCare that would have to go into a nursing home right away if less costly home care isn't available. We must decide if you would go into a nursing home right away and provide proof to TennCare. And we must show TennCare that there are home care providers ready to start giving you care at home.

Some slots will be held back (or reserved) for emergencies. This includes things like when a person is leaving the hospital and will be admitted to a nursing home if home care isn't available. Reserved slots won't be used until all the other slots have been filled. The number of reserved slots and the guidelines to qualify in one of those slots is in TennCare Rules. If the only slots left are reserved, you'll have to meet the guidelines for reserved slots to enroll in CHOICES Group 2 or Group 3.

If you don't meet the guidelines for reserved slots or there are no slots available and you qualify to enroll in CHOICES Group 2 or Group 3, your name will be placed on a waiting list. Or, if you meet the guidelines for CHOICES Group 2, you can choose to enroll in CHOICES Group 1 and receive nursing home care. There's no limit on the number of people that can be enrolled in Group 1 and go into a nursing home. (But you don't have to receive nursing home care unless you want to. You can wait for home care instead.)

People enrolled in CHOICES Group 2 above the enrollment target must get the first slots that open up. (These are people who have moved out of nursing homes or people already on TennCare and would have gone into a nursing home right away if less costly home care wasn't available.)

When everyone in CHOICES Group 2 is under the enrollment target and there are still slots available, TennCare can enroll from the waiting list based on need.

E4. Receiving Services in the CHOICES Program

The covered long-term services and supports you can receive in CHOICES depend on the CHOICES Group you're enrolled in. If you enroll in CHOICES, TennCare will tell you which CHOICES Group you're in. **There are three (3) CHOICES Groups.**

People in **CHOICES Group 1** receive nursing home care.

People in **CHOICES Group 2** need the level of care provided in a nursing home but receive home care (or HCBS) instead of nursing home care. Everyone in CHOICES Group 2 has an individual cost neutrality cap which is usually related to the average cost of nursing home care. This amount is updated every year.

People in **CHOICES Group 3** receive home care (or HCBS) to prevent or delay the need for nursing home care. There's an $18,000 per year limit on services in CHOICES Group 3.

The kinds of home care covered in CHOICES Group 2 and Group 3 are included below. Some of these services have limits. This means that TennCare will pay for only a certain amount of these services. The kind and amount of care you get in CHOICES depends on your needs.

These services include:

Personal care visits (up to 2,580 hours per calendar year) – Someone will help you with personal care needs and support in the home, on the job, or in the community. Do you need this kind of personal care? If you do, the worker giving your personal care visits can also help with household chores like fixing meals, cleaning, or laundry. And they can run errands like grocery shopping or picking up your medicine.

- They can only help with those things for you, not for other family members who aren't in CHOICES. And they can only do those things if there's no one else that can do them for you.

Home-delivered meals (up to 1 meal per day).

Adult day care (up to 2,080 hours per calendar year) – A place that provides supervised care and activities during the day.

In-home respite care (up to 216 hours per calendar year) – Someone to come and stay with you in your home for a short time so your caregiver can get some rest.

In-patient respite care (up to 9 days per calendar year) – A short stay in a nursing home or assisted care living facility so your caregiver can get some rest.

Assistive technology (up to $900 per calendar year) – Certain low-cost items or devices that help you do things easier or safer in your home like grabbers to reach things.

Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime) – Certain changes to your home that will help you get around easier and safer in your home like grab bars or a wheelchair ramp.

Pest control (up to 9 units per calendar year) – Spraying your home for bugs or mice.

Assisted Care Living Facility – A place you live that helps with personal care needs, homemaker services and taking your medicine. You must pay for your room and board.

Critical Adult Care Home – A home where you and no more than 4 other people live with a health care professional that takes care of special health and long-term care needs. (Under state law, available only for people who are ventilator dependent or who have traumatic brain injury. You must pay for your room and board.) Critical Adult Care Homes are available for Group 2 members ONLY.

Companion Care – Someone you hire who lives with you in your home to help with personal care or light housekeeping whenever you need it. (Available only for people in Consumer Direction who are in Group 2 and who need care off and on during the day and night that can't be provided by unpaid caregivers. And only when it costs no more than other kinds of home care that would meet your needs.)

Community Living Supports (CLS) – A shared home or apartment where you and no more than 3 other people live. The level of support provided depends on your needs and can include hands-on assistance, supervision, transportation and other supports needed to remain in the community.

Community Living Supports – Family Model (CLS-FM) – A shared home or apartment where you and no more than 3 other people live with a trained host family. The level of support provided depends on your needs and can include hands-on assistance, supervision, transportation and other supports needed to remain in the community.

Enabling technology is a new service (up to $5,000 per calendar year) – Enabling technology is the use of various forms of devices and technology to support independent living such as sensors, mobile applications, remote support systems and other smart devices. Enabling Technology can support a person in navigating their jobs and communities, gain more control of their environment, and provide remote support and reminders to assist a person in independent living.

Coverage decisions for Long-Term Services and Supports

Sometimes you may have to ask us if we cover your medical care or behavioral health (mental health or substance use disorder) services before you receive them even if a doctor says you need the services. This is called a coverage decision. Please review **Chapter 9** for more information on what to do, if this occurs.

Using Long-Term Services and Supports Providers Who Work with UHC Dual Complete TN-Y001

Just like health care and behavioral health services, you must use providers who work with us for most long-term services and supports. You can find the **Provider Directory** online at **MyUHC.com/CommunityPlan**. Or call us at **1-800-690-1606**, TTY **711** to get a list. Providers may have signed up or dropped out after the list was printed. But the online Provider Directory is updated every week. You can also call us at **1-800-690-1606**, TTY **711** to find out if a provider is in our network.

In most cases, you must receive services from a long-term services and supports provider on this list so that TennCare will pay for your long-term services and supports. However, there are times when TennCare will pay for you to get care from a long-term services and supports provider who doesn't usually work with us. But, we must first say that it's OK to use a long-term services and supports provider who doesn't usually work with UHC Dual Complete TN-Y001 (HMO-POS D-SNP).

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

You **don't** need to see your PCP before getting behavioral health services. But, you'll need to get your care from someone who is in our network.

A Community Mental Health Agency (CMHA) is one place you can go for mental health or substance use disorder services. Most CMHAs take TennCare.

G. How to get consumer directed care

G1. What consumer directed care is

Consumer Direction is a way of getting some of the kinds of home care you need. It offers more choice and control over **who** gives your home care and **how** your care is given. In CHOICES, the services available through Consumer Direction are:

- personal care visits;
- in-home respite; and
- companion care (Only if you qualify for and are enrolled in CHOICES Group 2).

G2. Who can get consumer directed care (for example, if it's limited to waiver populations)

In Consumer Direction, you actually employ the people who give some of your home care services — they work **for you** (instead of a provider). You must be able to do the things that an employer would do. These include things like:

1. Hiring and training your workers
   - Find, interview and hire workers to provide care for you.
   - Define workers' job duties.
   - Develop a job description for your workers.
   - Train workers to deliver your care based on your needs and preferences.
2. Setting and managing your workers' schedule
   - Set the schedule at which your workers will give your care.
   - Make sure your workers clock in and out using an Electronic Visit Verification (EVV) system **every** time they work.
   - Make sure your workers provide only as much care as you're approved to receive.
   - Make sure that no hourly worker gives you more than 40 hours of care in a week.
3. Supervising your workers
   - Supervise your workers.
   - Evaluate your workers' job performance.
   - Address problems or concerns with your workers' performance.
   - Fire a worker when needed.

4. Overseeing workers' pay and service notes
   - Decide how much your workers will be paid (within limits set by the state).
   - Review the time your workers report to be sure it's right.
   - Ensure there are good notes kept in your home about the care your workers provide.
5. Having and using a back-up plan when needed
   - Develop a back-up plan to address times that a scheduled worker doesn't show up (you can't decide to just go without services).
   - Activate the back-up plan when needed.

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

If you can't do some or all of these things? Then you can choose a family member, friend, or someone close to you to do these things for you. It's called a "Representative for Consumer Direction." It's important that you pick someone who knows you very well that you can depend on. To be your Representative for Consumer Direction, the person must:

- Be at least 18 years of age.
- Know you very well.
- Understand the kinds of care you need and how you want care to be given.
- Know your schedule and routine.
- Know your health care needs and the medicine you take.
- Be willing and able to do **all** of the things that are required to be in Consumer Direction.
- Live with you in your home **or** be present in your home often enough to supervise staff. This usually means at least part of every worker's shift. But it may be less as long as it's enough to be sure you're getting the quality of care you need.
- Be willing to sign a Representative Agreement, saying they agree to do these things.

Your Representative can't get paid for doing these things.

You or your Representative will have help doing some of the things you must do as an employer. The help will be provided by a Fiscal Employer Agent (also called FEA). There are 2 kinds of help you'll receive:

1. The FEA will help you and your workers fill out all of the paperwork that you must complete. They'll pay your workers for the care they give. And, they'll fill out and file the payroll tax forms that you must fill out as an employer.

2. The FEA will hire or contract with a Supports Broker for you. A Supports Broker is a person who will help you with the other kinds of things you must do as an employer. These are things like:
   - Writing job descriptions;
   - Helping you and your workers with paperwork and training;
   - Scheduling workers based on your support plan; and
   - Developing an initial back-up plan to address times when a scheduled worker doesn't show up.

But, your Supports Broker can't help you supervise your workers. You or your Representative must be able to do that by yourself.

The kind and amount of care you'll get depends on what you need. Those services are listed in your support plan. You won't be able to get more services by choosing to be in Consumer Direction. You can only get the services you need that are listed in your support plan.

You can choose to get some of these services through Consumer Direction **and** get some home care from providers that work with your TennCare health plan. But, you must use providers that work with MCO for care that you can't get through Consumer Direction.

Can you pay a family member or friend to provide care in Consumer Direction? Yes, you can pay a family member, but you can't:

- Pay your spouse to provide care;
- Pay someone who lives with you to provide personal care or in-home respite services;
- Pay an immediate family member to provide Companion Care. An immediate family member is a spouse, parent, grandparent, child, grandchild, sibling, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, and son-in-law. Adopted and step members are included in this definition;
- Pay someone who lives with you now or in the last 5 years to provide companion care.

And, CHOICES can't pay family members or others to provide care they would have given for free. CHOICES only pays for care to meet needs that **can't** be met by family members or others who help you. The services you need are listed in your support plan.

If you're in CHOICES and need services that can be consumer directed your care coordinator will talk with you about Consumer Direction. If you want to be in Consumer Direction, your care coordinator will work with you to decide which of the services you'll direct and start the process to enroll you in Consumer Direction. Until Consumer Direction is set up, you'll get the services that are in your support plan from a provider who works with UHC Dual Complete TN-Y001 (HMO-POS D-SNP), unless **you choose** to wait for your Consumer Directed workers to start. If you choose to wait for your Consumer Directed workers to start, you must have supports in place to give you the care you need.

? **If you have questions,** please call UHC Dual Complete TN-Y001 (HMO-POS D-SNP) at **1-800-690-1606** (TTY **711**), 8am–8pm: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. For more information, visit **MyUHC.com/CommunityPlan**.

You can decide to be in Consumer Direction at any time. If you're directing one or more services and decide not to be in Consumer Direction anymore, you **won't** stop getting long-term services and supports. You'll still be in CHOICES. You'll get the services you need from a provider who works with UHC Dual Complete TN-Y001 (HMO-POS D-SNP) instead.

H. Transportation services

If you don't have a way to get to your health care visits, you may be able to get a ride from TennCare.

You can get help with a ride:

- **Only** for services covered by TennCare, and
- **Only** if you don't have any other way to get there.

You can have someone ride with you to your appointment if:

- You're a child under the age of 21 or
- You have a disability or need help to get the service (like someone to open doors for you, push your wheelchair, help you with reading or decision making).

Try to call **at least 72 hours before** your health care appointment to make sure that you can get a ride. If you change times or cancel your health care appointment, you must change or cancel your ride too.

Routine transportation not for use in emergencies.

For scheduling a ride call 1-866-405-0238.

If you need a ride to your appointment or have questions about having someone ride with you, call us at **1-800-690-1606**, TTY **711**.

I. Covered services in a medical emergency, when urgently needed, or during a disaster

I1. 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 and, if you're pregnant, loss of an unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**

- In the case of a pregnant woman in active labor, when:
  - There isn't enough time to safely transfer you to another hospital before delivery.
  - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

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 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.
- **As soon as possible, tell our plan about your emergency.** We follow up on your emergency care. You or your care coordinator 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. Please call us toll-free at **1-800-690-1606**, TTY **711**. Available 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept.

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 **Evidence of Coverage**.

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.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible.

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.

I2. 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's not 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 and Pharmacy Directory** for a list of network Urgent Care Centers or call Customer Service at **1-800-690-1606**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept for more information. **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.

Show your plan card when you get the urgently needed care. Ask the provider to send the bill to us. If the provider says no, ask if they'll send the bill to you at home. Or if you have to pay for the care, get a receipt.

When you get home, call us and tell us you had to pay for your health care or that you have a bill for it. We'll work with you and the provider to put in a claim for your care.

Our plan covers worldwide emergency and urgently needed care services outside the United States and its territories 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. Prescheduled, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures are not covered.

I3. Care during a disaster

If the governor of your state, 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 prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this **Evidence of Coverage** for more information.

J. What to do if you are 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 **Evidence of Coverage** 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.

J1. What to do if our plan doesn't cover services

You won't have to pay for services that are covered by TennCare. If you choose to pay out of pocket for a covered service, you WON'T be reimbursed. 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 **Evidence of Coverage**), **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 will not pay for your services, you have the right to appeal our decision.

Chapter 9 of this **Evidence of Coverage** 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 Customer Service 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 Customer Service to find out what the benefit limits are and how much of your benefits you've used.

K. Coverage of health care services in a clinical research study

K1. 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 a coverage decision 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 coordinator to contact Customer Service to let us know you'll take part in a clinical trial.

K2. 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.

K3. 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 (medicare.gov/sites/default/files/201909/02226-medicare-and-clinical-research-studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

L. How your health care services are covered in a religious non-medical health care institution

Sometimes your provider can't give you the care or treatment you need because of their conscience/ethical/moral or religious reasons. Call us at **1-800-690-1606**, TTY **711**. We can help you find a provider who can give you the care or treatment you need.

L1. 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).

L2. 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 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 that are 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.

You are covered for unlimited days in the hospital, as long as your stay meets Medicare coverage guidelines. The coverage limits are described under Inpatient Hospital Care in the Medical Benefits Chart in Chapter 4.

M. Durable medical equipment (DME)

M1. 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 items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you **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.

M2. 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.

M3. 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.

M4. 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. 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 **Evidence of Coverage**.

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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 **Evidence of Coverage**.

Because you get help from TennCare you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of this **Evidence of Coverage** for details about our plan's rules.

If you need help understanding what services are covered, call your care coordinator or Customer Service at **1-800-690-1606**, TTY **711**.

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 **Evidence of Coverage** or call Customer Service.

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 TennCare covered services according to the rules set by Medicare and TennCare.
- The services (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs) 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 **Evidence of Coverage** has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is 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 **Evidence of Coverage** 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 in **bold** 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.

All preventive services are free. You will find this apple next to preventive services in the Benefits Chart.

Important Benefit Information for Members with Certain Chronic Conditions.

- If you're diagnosed with any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
  - **Qualifying conditions are:** 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, 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, and conditions with functional challenges and require similar services.
  - Your eligibility will be determined after you enroll in this plan. We'll validate that you have one or more of the qualifying chronic conditions from your treating providers. In addition, we'll confirm you meet additional criteria including high-risk for hospitalization or serious health outcomes and require intensive care coordination, such as help managing multiple providers or medications.For more detail, go to the Special Supplemental Benefits for the Chronically Ill row in the Medical Benefits Chart below.

- Contact us to find out exactly which benefits you may be eligible for.

D. Our plan's Benefits Chart

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).

Covered Service	What you 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.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening

Covered Service	What you pay
Acupuncture We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, 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. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. **Generally, Medicare-covered acupuncture services are not covered when provided by an acupuncturist or chiropractor.** 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 masters 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 copayment **Your provider may need to obtain prior authorization.** **Referral may be required**

Covered Service	What you 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. • Benefit is not covered when solely provided by an independent acupuncturist. 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.	
Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. 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 copayment

Covered Service	What you pay
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 copayment for each one-way Medicare-covered trip by ground. $0 copayment for each one-way Medicare-covered trip by air. Non-emergency ambulance services are not covered out-of-network. **Your provider may need to obtain prior authorization for non-emergency transportation.**
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. Annual Routine Physical Exam visits do not need to be scheduled 12 months apart but are limited to one each calendar year.	$0 copayment for a routine physical exam each year

Covered Service	What you pay
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. 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. **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.	There is no coinsurance, copayment, or deductible for the annual wellness visit
Behavioral health crisis services (mental health, alcohol, and drug abuse services) (TennCare-covered) TennCare covers you for this care. Medicare does not cover this care.	$0 copayment
Behavioral health intensive community based treatment (TennCare-covered) TennCare covers you for this care. Medicare does not cover this care.	$0 copayment
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.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement

Covered Service	What you pay
Breast cancer screening (mammograms) We pay for the following services: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and over • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms
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 order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0 copayment for each Medicare-covered cardiac rehabilitative visit. **Your provider may need to obtain prior authorization.**
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.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit
Cardiovascular (heart) disease screening tests We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years

Covered Service	What you pay
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 • For women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months • For asymptomatic women between the ages of 30 and 65: HPV testing once every 5 years, in conjunction with the Pap test	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams

Covered Service	What you 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: • 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, hand-held 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). TennCare covers you if you are under age 21 and don't have Medicare coverage. Medicare covers if you're 21 and older.	$0 copayment for each Medicare-covered visit. **Your provider may need to obtain prior authorization.**
Routine Chiropractic Services We cover 20 routine chiropractic visits every year. This benefit is in addition to the Medicare-covered Chiropractic Services benefit listed above. Covered services include routine visits to treat nerve, muscle, and/or bone pain and nausea. No referral required. This benefit does not cover treatment for any other conditions not related to pain relief. For more information, check the Vendor Information Sheet at **MyUHC.com/CommunityPlan** or call Customer Service to have a paper copy sent to you.	$0 copayment

Covered Service	What you pay
CHOICES benefits (nursing facility care and certain home and community-based services, HCBS) TennCare covers you for this care. Medicare does not cover this care. Medicare is primary for Skilled Nursing Facility care. For more information on CHOICES, see Chapter 4, Section E5	$0 copayment

Covered Service	What you pay
Chronic care management services, including chronic pain management and treatment plan services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. 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.	For your monthly chronic care management plan, you will pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/ practitioner services, including doctor's office visits") depending on the type of provider who developed your plan. For any care recommended under your plan, you will pay the applicable cost-sharing. Services recommended under chronic pain management plans may include (but are not limited to) primary care services, specialist physician services, physical therapy, occupational therapy, lab or diagnostic tests, or prescription drugs (as described under "Physician/practitioner services, including doctor's office visits", "Outpatient rehabilitation services", "Outpatient diagnostic tests and therapeutic services and supplies", or "Medicare Part B Drugs", or see Chapter 6 for what you pay for applicable Part D drugs). **Your provider may need to obtain prior authorization** **Referral may be required**

Covered Service	What you pay
Colorectal cancer screening We 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 45 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 45 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 or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. **This benefit is continued on the next page**	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam and colonoscopy. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes an outpatient diagnostic colonoscopy.

Covered Service	What you pay
Colorectal cancer screening (continued) • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive 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	There is no coinsurance, copayment, or deductible for each Medicare-covered diagnostic colonoscopy. **Your provider may need to obtain prior authorization.**
Community health clinic services (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment
Dental services Certain dental services, including cleanings, fillings, and dentures, are available through the DentaQuest Dental Program. 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 after.	$0 copayment **Your provider may need to obtain prior authorization.**

Covered Service	What you pay
Routine dental benefits You can get more information by viewing the Vendor Information Sheet at **MyUHC.com/CommunityPlan** or by calling Customer Service to have a paper copy sent to you.	You are covered for routine dental benefits. See the routine dental benefit description at the end of this chart for details.* **Your provider may need to obtain prior authorization.**
Dental services (TennCare-covered) TennCare covers you if you are under age 21 and don't have Medicare coverage. Medicare covers if you're 21 and older.	$0 copayment
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.	There is no coinsurance, copayment, or deductible for an annual depression screening visit
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 two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests

Covered Service	What you 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): • 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 BGMs and test strips in this list. We don't usually cover other BGM 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.	$0 copayment for each Medicare-covered continuous glucose monitor (CGM) and supplies with an approved prior authorization. There are no brand limitations for CGMs. **Your provider may need to obtain prior authorization.** $0 copayment for each Medicare-covered blood glucose monitor (BGM). **Your provider may need to obtain prior authorization.** $0 copayment for each Medicare-covered diabetes monitoring supply. For BGMs, we only cover Contour® and Accu-Chek® brands. Other BGM brands aren't 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.

Covered Service	What you pay
Diabetic self-management training, services, and supplies (continued) If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your condition. (For more information about appeals, see Chapter 9.)	
• 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** – 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)	$0 copayment for each pair of Medicare-covered therapeutic shoes. **Your provider may need to obtain prior authorization.**
• In some cases, we pay for training to help you manage your diabetes. To find out more, contact Customer Service. – Diabetes self-management training is covered under certain conditions. Limited to 20 visits of 30 minutes per year for a maximum of 10 hours the initial year. Follow up training subsequent years after, limited to 4 visits of 30 minutes for a maximum of 2 hours per year.	$0 copayment for Medicare-covered benefits.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of this **Evidence of Coverage** 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 TennCare usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.	$0 copayment for Medicare-covered benefits. **Your provider may need to obtain prior authorization.** Your cost-sharing for Medicare oxygen equipment coverage is $0 copayment, every time you get covered equipment or supplies. **Your provider may need to obtain prior authorization.** Your cost-sharing will not change after being enrolled for 36 months. If prior to enrolling in our plan you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in our plan is $0 copayment. **Your provider may need to obtain prior authorization.**
Durable Medical Equipment (DME) (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment **Your provider may need to obtain prior authorization.**
Emergency air and ground ambulance (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment

Covered Service	What you 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 to that of your unborn child; **or** • Serious harm to bodily functions; **or** • loss of a limb, or loss of function of a limb. • **In the case of a pregnant woman in active labor, when:** – There isn't enough time to safely transfer you to another hospital before delivery. – A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.	Within the United States: $0 copayment for each emergency room visit. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.
Worldwide coverage for emergency department services. • 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. **This benefit is continued on the next page**	Outside the United States: $0 copayment for Worldwide coverage for emergency services outside of the United States. In most cases you will prepay the foreign provider for the service and request reimbursement. Please see **Chapter 7 Section A** for expense reimbursement for worldwide emergency services.

Covered Service	What you pay
Emergency care (continued) • Services provided by a dentist are not covered. • Provider access fees, appointment fees and administrative fees are not covered. • 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.	
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 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, Section O**) 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 Customer Service to have a paper copy sent to you.	$0 copayment 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.
Hearing services 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.	$0 copayment for each Medicare-covered exam. **Your provider may need to obtain prior authorization.**

Covered Service	What you pay
Hearing services – routine hearing exam We cover 1 hearing exam every year.	$0 copayment
Hearing services – hearing aids Through UnitedHealthcare Hearing, you can choose from a broad selection of over-the-counter (OTC) and prescription hearing aids. This includes brand-name manufacturers, as well as Relate®, UnitedHealthcare Hearing's private-label brand that offers affordable, high-quality hearing aids with a variety of technology options and helpful features. Hearing aids can be fit in-person with a network provider or delivered directly to you (select products only) This benefit is limited to 2 hearing aids every 2 years. Hearing aid accessories, additional batteries and optional services are available for purchase, but they are not covered by the plan. You can get more information by viewing the Vendor Information Sheet at **MyUHC.com/CommunityPlan** or by calling Customer Service to have a paper copy sent to you.	Provided by: UnitedHealthcare Hearing Hearing aid allowance is $3,200 Contact UnitedHealthcare Hearing to access your hearing aid benefit and get connected with a network provider. **You must obtain prior authorization from UnitedHealthcare Hearing. Additional fees may apply for optional follow-up visits.** Home-delivered hearings aids are available nationwide through UnitedHealthcare Hearing (select products only). Hearing aids purchased outside of UnitedHealthcare Hearing are not covered.
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.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening

Covered Service	What you 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. **Community Living Supports (CLS)** is a covered home health agency service/ benefit. A CLS is a shared home or apartment where you and no more than 3 other people live. The level of support provided depends on your needs and can include hands-on assistance, supervision, transportation, and other supports needed to remain in the community. We pay for the following additional home health 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 each day and 28 or fewer hours each week (or up to 35 hours a week in some limited situations)) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met. **Your provider may need to obtain prior authorization** Other copayments or coinsurance may apply (Please see Durable medical equipment and related supplies for applicable copayments or coinsurance).

Covered Service	What you 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 copayment **Your provider may need to obtain prior authorization** **Referral may be required** See "Durable medical equipment" earlier in this chart for any applicable cost-sharing for equipment and supplies related to home infusion therapy. **Your provider may need to obtain prior authorization** See "Medicare Part B prescription drugs" later in this chart for any applicable cost-sharing for drugs related to home infusion therapy. **Your provider may need to obtain prior authorization** See Chapter 6 for any applicable cost-sharing for Part D drugs related to home infusion therapy.

Covered Service	What you 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 **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**	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not UHC Dual Complete TN-Y001 (HMO-POS D-SNP).

Covered Service	What you 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 **Evidence of Coverage**. **Note:** If you need non-hospice care, call your care coordinator and/or Customer Service 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.	
Hospice care (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment
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 **Evidence of Coverage** to learn more.	There is no coinsurance, copayment, or deductible for the pneumonia, flu, Hepatitis B, and COVID-19 vaccines. There is no coinsurance, copayment, or deductible for all other Medicare-covered Immunizations.

Covered Service	What you 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 copayment for each Medicare-covered hospital stay for unlimited days each time you are admitted. **Your provider may need to obtain prior authorization.** If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you'd pay at a network hospital. Medicare hospital benefit periods do not apply. (See definition of benefit periods in Chapter 12.) For inpatient hospital care, the cost sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

Covered Service	What you pay
Inpatient hospital care (continued) 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, please call UHC Dual Complete TN-Y001 (HMO-POS D-SNP) Customer Service at 1-800-690-1606 TTY 711. 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. • 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-HospitalBenefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	Outpatient observation cost sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.

Covered Service	What you pay
Inpatient hospital services (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment **Your provider may need to obtain prior authorization**
Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. Covered services include: • Mental 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 Mental Health services provided in a psychiatric unit of a general hospital. • Inpatient substance abuse services	$0 copayment up to 90 days per benefit period, plus an additional 60 lifetime reserve days. **Your provider may need to obtain prior authorization.** Medicare hospital benefit periods are used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in the chapter titled Definitions of important words.) However, the cost-sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times within a benefit period.

Covered Service	What you pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We don't pay for your inpatient stay if you've used all of your inpatient benefit or if the stay isn't reasonable and medically necessary. However, in certain situations where inpatient care isn't covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Customer Service. We pay for the following services, 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	$0 copayment

Covered Service	What you 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.	$0 copayment for Medicare-covered benefits
• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this **Evidence of Coverage**, or when your provider for this service is temporarily unavailable or inaccessible.	$0 copayment for Medicare-covered benefits **Your provider may need to obtain prior authorization**
• 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 copayment for Medicare-covered benefits
Lab and x-ray services (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment

Covered Service	What you 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.	$0 copayment
Meal Benefit This benefit can be used immediately following a covered inpatient hospital or skilled nursing facility stay (SNF) if recommended by a provider. Benefit guidelines: • Receive up to 28 home-delivered meals for up to 14 days • First meal delivery may take up to 72 hours after ordered • Referrals must be placed within 30 calendar days of discharge Call Customer Service to get more information.	$0 copayment **Your provider may need to obtain prior authorization** Home-delivered meals are available nationwide.

Covered Service	What you pay
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 three 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 two 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 the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services
Medical supplies (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment
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.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Covered Service	What you 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 **This benefit is continued on the next page**	$0 copayment for each Medicare-covered Part B drug **Your provider may need to obtain prior authorization for some services/drugs** $0 copayment for each Medicare-covered chemotherapy drug and the administration of that drug **Your provider may need to obtain prior authorization for some services/drugs**

Covered Service	What you pay
Medicare Part B drugs (continued) • 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 • 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 phosphate 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) We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **This benefit is continued on the next page**	

Covered Service	What you pay
Medicare Part B drugs (continued) **Chapter 5** of this **Evidence of Coverage** explains our outpatient drug benefit. It explains rules you must follow to have covered. **Chapter 6** of this **Evidence of Coverage** explains what you pay for your drugs through our plan.	
Non-Emergency transportation (NEMT) and scheduling assistance Transportation services are available to all TennCare members who don't have access to transportation and need assistance to and from a covered medically necessary service.	$0 copayment

Covered Service	What you 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. CHOICES benefits (Nursing Facility care and certain Home and Community Based Services, HCBS) are included in these services. 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 **This benefit is continued on the next page**	$0 copayment A member may have a patient liability based on the member's income.

Covered Service	What you pay
Nursing facility care (continued) • Chiropractic care • Podiatry services 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.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy
Occupational therapy In-home assessments and recommendations by a Licensed Occupational Therapist pertaining to the use of technology to restore, improve, or stabilize impaired functions.	$0 copayment **Your provider may need to obtain prior authorization**

Covered Service	What you pay
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) • Dispensing and administration of MAT medications (if applicable) • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.	$0 copayment for Medicare-covered opioid treatment program services **Your provider may need to obtain prior authorization**
Organ and tissue tranplants and donor organ services TennCare covers you for this care. Medicare is primary.	$0 copayment

Covered Service	What you 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 **This benefit is continued on the next page**	You pay a $0 copayment for each Medicare covered: • Standard X-ray service. • Radiation therapy service. • Medical supply. • Lab services. • Blood services. • Non-radiological diagnostic services. Examples include, but are not limited to EKG's, pulmonary function tests, home or lab-based sleep studies and treadmill stress tests. • Radiological diagnostic services, not including X-rays, performed in a physician's office or at a freestanding facility (such as a radiology center or medical clinic). **Your provider may need to obtain prior authorization for services**

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued)	The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies). $0 copayment for Medicare-covered radiological diagnostic services, not including X rays. **Your provider may need to obtain prior authorization for services**

Covered Service	What you 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-HospitalBenefits.pdf	$0 copayment **Your provider may need to obtain prior authorization**

Covered Service	What you 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	$0 copayment You pay a $0 copayment for each Medicare covered office visit with a Primary Care Provider. You pay a $0 copayment for each Medicare covered office visit with a Specialist. **Your provider may need to obtain prior authorization**
Outpatient hospital services (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment

Covered Service	What you pay
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 • any other Medicare-qualified mental health care professional as allowed under applicable state laws Outpatient Behavioral health services include: • all laboratory services in an inpatient, outpatient, or professional setting • uncategorized professional services (such as evaluation and management, health screenings, and specialists' visits) • mental health and substance use disorder services • crisis services • outpatient radiology • outpatient professional services • therapy • assessment & testing • substance use treatment • medication management • counseling/Intervention • detox **This benefit is continued on the next page**	$0 copayment for each Medicare-covered **individual** therapy session **Your provider may need to obtain prior authorization** $0 copayment for each Medicare-covered **group** therapy session **Your provider may need to obtain prior authorization**

Covered Service	What you pay
Outpatient mental health care (continued) • rehab • other E&M • other behavioral health treatment	
Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0 copayment for each Medicare-covered physical therapy and speech-language therapy visit **Your provider may need to obtain prior authorization.** **Requires a referral from your doctor.** $0 copayment for each Medicare-covered occupational therapy visit. **Your provider may need to obtain prior authorization.** **Requires a referral from your doctor.**
Outpatient substance use disorder treatment 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 copayment for each Medicare-covered **individual** therapy session **Your provider may need to obtain prior authorization** $0 copayment for each Medicare-covered **group** therapy session **Your provider may need to obtain prior authorization**

Covered Service	What you pay
Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes 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 receive any services or items other than surgery, including but not limited to diagnostic tests, therapeutic services, prosthetics, orthotics, supplies or Part B drugs, there may be additional cost-sharing for those services or items. Please refer to the appropriate section in this chart for the additional service or item you received for the specific cost-sharing required. See "Colorectal cancer screening" earlier in this chart for screening and diagnostic colonoscopy benefit information.	$0 copayment for Medicare-covered surgery, other services, or each day of observation provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges **Your provider may need to obtain prior authorization** Outpatient surgical services that can be delivered in an available ambulatory surgery center must be delivered in an ambulatory surgery center unless a hospital outpatient department is medically necessary. $0 copayment for each day of Medicare-covered observation services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges. **Your provider may need to obtain prior authorization.**

Covered Service	What you 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 credits expire 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 $395
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.	Combined with OTC credit amount
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, healthy food and utilities will be included as part of your OTC credit expiring monthly. Your eligibility for the healthy food and utilities 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) **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.

Covered Service	What you pay
Over-the-counter (OTC) credit (continued) • Chronic hyperlipidemia (chronic high cholesterol) • Autoimmune disorders • Cancer • 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. **This benefit is continued on the next page**	

Covered Service	What you pay
Over-the-counter (OTC) credit (continued) 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.	
Partial hospitalization services and intensive outpatient services **Partial hospitalization** is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is 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 is 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.	$0 copayment each day for Medicare-covered benefits **Your provider may need to obtain prior authorization**
Pharmacy services (TennCare-covered) TennCare covers you for this care with limits. Medicare is primary. For information on your Part D benefits, if you have them, please see Chapter 5.	$0 copayment
Physical therapy services (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment **Your provider may need to obtain prior authorization.**

Covered Service	What you pay
Physician services (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment

Covered Service	What you 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 – 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 network provider who offers the service by telehealth. • 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 • 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 **This benefit is continued on the next page**	$0 copayment for services from a primary care provider or under certain circumstances treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a primary care provider's office (as allowed by Medicare). $0 copayment for each Medicare-covered hearing exam. **Your provider may need to obtain prior authorization.** $0 copayment for services from a primary care provider or under certain circumstances treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a primary care provider's office (as allowed by Medicare). **Your provider may need to obtain prior authorization** **Requires a referral from your doctor.** $0 copayment for telehealth services

Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) – 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. • 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, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of your location **This benefit is continued on the next page**	$0 copayment for each Medicare-covered visit. **Your provider may need to obtain prior authorization.** **Referral is required**

Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) • 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 • 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 **This benefit is continued on the next page**	

Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) • Second opinion prior to surgery • Monitoring services in a physician's office or outpatient hospital setting if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as 'Coumadin Clinic' services). • Medically-necessary services that are covered benefits and are furnished by a physician/non-physician health care professional in your home. **This benefit is continued on the next page**	You will pay the cost-sharing that applies to specialist services (as described under "Physician/practitioner services, including doctor's office visits" above). **Your provider may need to obtain prior authorization** **Referral is required** You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you receive services. **Your provider may need to obtain prior authorization.** **Referral may be required.** $0 copayment for nurse practitioner, physician's assistant or other non physician health care professional services. **Your provider may need to obtain prior authorization.**

Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued)	For primary care provider services or specialist physician services, you will pay the cost sharing as applied in an office setting described above in this section of the benefit chart. **Your provider may need to obtain prior authorization** **Referral may be required.**
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 copayment for each Medicare-covered visit in an office or home setting. **Your provider may need to obtain prior authorization** For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Additional Routine Foot Care We cover 4 routine foot care visits every year. This benefit is in addition to the Medicare-covered podiatry services benefit listed above. Covered services include treatment of the foot which is generally considered preventive, i.e., cutting or removal of corns, warts, calluses or nails.	$0 copayment for each routine visit

Covered Service	What you pay
Pre-exposure prophylaxes (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.	There is no coinsurance, copayment, or deductible for the PrEP benefit.
Private duty nursing services Must be prescribed by attending physician for treatment and service rendered by a registered nurse a licensed practical nurse.	$0 copayment **Your provider may need to obtain prior authorization**
Prostate cancer screening exams For men aged 50 and over, we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	There is no coinsurance, copayment, or deductible for each Medicare-covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test.

Covered Service	What you 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 copayment for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies. **Your provider may need to obtain prior authorization.**
Psychiatric inpatient facility services (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment
Psychiatric rehabilitation services (TennCare-covered) TennCare covers you for this care. Medicare does not cover these services.	$0 copayment
Psychiatric residential treatment services (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment

Covered Service	What you pay
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 an order for pulmonary rehabilitation from the doctor or provider treating the COPD. Medicare covers up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of pulmonary rehabilitation services.	$0 copayment for each Medicare-covered pulmonary rehabilitative visit **Your provider may need to obtain prior authorization**
Reconstructive breast surgery Surgery to restore a breast to near normal shape, appearance, and size after having a mastectomy due to cancer. This includes: • Reconstructive surgery for a cancerous breast; and • Reconstructive surgery for a breast without cancer so that the breasts are the same size and shape This surgery is covered as long as it's done within five years of the reconstructive surgery on the diseased breast.	$0 copayment
Renal dialysis (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment

Covered Service	What you 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus
Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for the STIs preventive benefit

Covered Service	What you 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 A 3-day prior hospital stay is not required. 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 copayment **Your provider may need to obtain prior authorization** You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Covered Service	What you 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).	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Speech therapy services (TennCare-covered) TennCare covers you for this care. Medicare is primary.	$0 copayment **Your provider may need to obtain prior authorization.**

Covered Service	What you pay
Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) 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 copayment for each Medicare-covered supervised exercise therapy (SET) visit **Your provider may need to obtain prior authorization.**

Covered Service	What you pay
Routine Transportation Details of this benefit: • Up to 120 one-way trips are covered each year (limited to ground transportation only). • Trips must be to or from plan-approved locations, such as network providers, medical facilities, pharmacies, routine dental, vision, hearing, adult day care, gym and chiropractic services covered by your D-SNP plan benefits. The locations must be in the plan service area and within 50 miles of the pickup location. • You are responsible for any costs over the trip limit. • Each one-way trip must not exceed 50 miles of driving distance. A trip is one-way transportation; a round trip is 2 trips. • Transportation services must be requested 72 hours prior to a routine scheduled appointment. • One companion is allowed per trip (companion must be at least 18 years old). • Trips are curb-to-curb service. • Wheelchair-accessible vans are available upon request. • Drivers do not have medical training. In case of an emergency, call 911. Routine transportation not for use in emergencies. This benefit does not cover transportation by: • Stretcher You can get more information by viewing the Vendor Information Sheet at **MyUHC.com/CommunityPlan** or by calling Customer Service to have a paper copy sent to you.	$0 copayment

Covered Service	What you pay
Urgently needed care Urgently needed care is care given to treat: • A non-emergency that requires immediate medical care, **or** • An unforeseen 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 because given your time, place, or circumstances, it is 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 copayment for each visit. $0 copayment for Worldwide coverage of urgently needed services outside of the United States. Please see **Chapter 7, Section A** for expense reimbursement for worldwide services.

Covered Service	What you pay
Vision care We 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, screening for diabetic retinopathy is covered once per year. One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (additional pairs of eyeglasses or contacts are not covered by Medicare). If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery. Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any upgrades aren't covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating). Original Medicare doesn't cover routine eye exams (including eye refractions) for eyeglasses/contacts. See Vision services — routine eye exam coverage below.	$0 copayment for each Medicare-covered visit. **Your provider may need to obtain prior authorization** $0 copayment for Medicare-covered glaucoma screening. $0 copayment for Medicare-covered eye exams to evaluate for eye disease. **Your provider may need to obtain prior authorization** $0 copayment for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.
Vision services – routine eye exam We cover 1 routine eye exam every year. Eye refraction is part of the routine eye exam benefit. You can get more information by viewing the Vendor Information Sheet at **MyUHC.com/CommunityPlan** or by calling Customer Service to have a paper copy sent to you.	Provided by: MARCH® Vision Care $0 copayment

Covered Service	What you pay
Vision services – routine eyewear 1 pair of lenses/frames and contact lenses every year You are responsible for any amount over the plan allowance for eyewear. You can get more information by viewing the Vendor Information Sheet at **MyUHC.com/CommunityPlan** or by calling Customer Service to have a paper copy sent to you.	Provided by: MARCH® Vision Care $0 copayment Plan pays up to $600 toward your purchase of lenses/frames and contact lenses.
Vision services (TennCare-covered) TennCare covers you for this care with limits if you are 21 or older. Medicare is primary. For adults age 21 and older, vision services are limited to medical evaluation and management of abnormal conditions and disorders of the eye. The first pair of cataract glasses or contact lens/lenses after cataract surgery are covered.	$0 copayment
"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. 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.	There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit. There is no coinsurance, copayment, or deductible for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" preventive visit. Please refer to outpatient diagnostic tests and therapeutic services and supplies for other EKG's.

Covered Routine Dental Benefits Included with Your Plan:

Annual Dental Maximum: $5,000

- As a part of your UnitedHealthcare Medicare Advantage plan you get a Routine Dental Benefit that provides coverage for preventive and other necessary dental services such as:
  - Exams
  - Cleanings
  - Fillings
  - X-rays
  - Crowns
  - Bridges
  - Root canals
  - Extractions
  - Partial dentures
  - Complete dentures
- $0 copay on all covered dental services up to the plan's annual dental maximum amount.
- All covered services have applicable frequency limitations. Some covered services may consider prior tooth history and procedures in conjunction with frequency limitations. If you wish to discuss detailed information about your plan with your dentist or see the full list of covered dental services with associated frequency limitations, you can find it in the UHC Dental Medicare quick reference guide at **uhcmedicaredentalproviderqrg.com**.
- Procedures used for cosmetic-only reasons (tooth bleaching/whitening, veneers, gingival recontouring, enamel microabrasion), orthodontics, space maintenance, implants and implant-related services, sales tax, charges for failure to keep appointments, dental case management, dental charges related to COVID screening, testing and vaccination, and unspecified procedures by report are not covered by the plan.
- After the annual maximum is exhausted, any remaining charges are your responsibility. All covered dental services paid for by the plan count toward the annual dental maximum.

Other limitations and exclusions are listed below.

- This dental plan offers access to the robust UHC Dental National Medicare Advantage Network. Network dentists have agreed to provide services at a negotiated rate. If you see a network dentist, you cannot be billed more than that rate for covered services within the limitations of the plan. Any fees associated with non-covered services are your responsibility.
- For assistance finding a provider, please use the dental provider search tool at **MyUHC.com/CommunityPlan**. You may also call **1-800-690-1606** for help with finding a provider or scheduling a dental appointment

- This dental plan offers both in-network and out-of-network dental coverage. Out-of-network dentists are not contracted to accept plan payment as payment in full, so they might charge you for more than what the plan pays, even for services listed as $0 copayment. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions.
- When you have covered dental services performed at a network dentist, the dentist will submit the claim on your behalf. When you see an out-of-network dentist, often the dentist will submit a claim on your behalf. If they do not, then you can submit it directly using the following instructions:
  - The claim submission must contain the following information:
    - Full member name and member ID number
    - Full provider name and address
    - List of dental services rendered with the corresponding ADA code(s)
    - Proof of payment in the form of a receipt, check copy, EOB, or a ledger statement from the provider showing a positive payment against the services rendered
  - Mail all required claim information within 365 days from the date of service to: **P.O. Box 644, Milwaukee, WI 53201**
  - Payment will be sent to the address listed on your account. To update your address or for assistance with submitting claims, contact Customer Service at **1-800-690-1606** TTY **711**.
  - Claims are paid within 30 days and an Explanation of Payment (EOP) will accompany check payment
- Dentists may ask you to sign an informed consent document detailing the risks, benefits, costs, and alternatives to all recommended treatments. If you would like to learn more how your dental plan coverage relates to your proposed dental treatment and costs, you may ask your dentist to obtain a pre-treatment cost calculation from UHC Dental. If the provider has questions about how to obtain this information, they can contact UHC Dental using the number or website on the back of your UnitedHealthcare UCard.
- Coordination of benefits (COB) — If you have a standalone dental plan in addition to the dental benefit offered with your UnitedHealthcare Medicare Advantage plan, it would be considered primary coverage and should be billed first. The dental coverage associated with your UnitedHealthcare Medicare Advantage plan would be considered secondary. If there is a remaining balance after the primary coverage has paid, your provider could bill UHC Dental for consideration of payment. UHC Dental will reduce their allowable amount (the amount the plan will pay for a covered service) by what the primary coverage/plan paid and is subject to any benefit maximums, limitations and/or exclusions.
- For all other questions or more information, please call **1-800-690-1606** TTY **711** or visit **MyUHC.com/CommunityPlan**

Exclusions:

1. Services performed by an out-of-network dentist if your plan does not have out-of-network coverage.
2. Dental services that are not necessary.
3. Hospitalization or other facility charges.
4. Any dental procedure performed solely for cosmetic and/or aesthetic reasons.
5. Any dental procedure not directly associated with a dental disease.
6. Any procedure not performed in a dental setting.
7. Reconstructive surgery of any type, including reconstructive surgery related to a dental disease, injury, or congenital anomaly.
8. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on dental therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
9. Service for injuries or conditions covered by workmen's compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county, or other political subdivision. This exclusion does NOT apply to any services covered by Medicaid or Medicare.
10. Expenses for dental procedures begun prior to the covered person’s eligibility with the plan.
11. Dental services rendered (including otherwise covered dental services) after the date on which individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date on which individual coverage under the policy terminates.
12. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.
13. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice, sales tax, or duplicating/copying patient records.
14. Implants and implant-related services.
15. Tooth bleaching and/or enamel microabrasion
16. Veneers
17. Orthodontics
18. Sustained release of therapeutic drug (D9613)

19. COVID screening, testing, and vaccination
20. Charges aligned to dental case management, case presentation, consultation with other medical professionals or translation/sign language services.
21. Space maintenance
22. Any unspecified procedure by report (Dental codes: D##99)

Disclaimer: Treatment plans and recommended dental procedures may vary. Talk to your dentist about treatment options, risks, benefits, and fees. CDT code changes are issued annually by the American Dental Association. Procedure codes may be altered during the plan year in accordance with discontinuation of certain dental codes.

E. Benefits covered outside of our plan

We don't cover the following services, but they're available through Medicare or TennCare.

E1. Population Health

Population Health services provide you with information on how to stay healthy. If you have an ongoing illness or unmet health needs, Population Health services can help you do things like:

- understand your illness and how to feel better
- help you or your child find a primary care doctor and get to your appointments
- develop a plan of care based on your doctor's or your child's doctor's advice for medical and behavioral health needs
- be a partner to you or your child to coordinate care with all of your health care providers
- have a healthy pregnancy and healthy delivery
- help with getting your prescription medications
- help keep you or your child out of the hospital by getting care in the community
- identify community organizations that can provide non-medical supports and resources to improve the health and well-being of you or your child
- help you with lifestyle changes that you want to make like quitting smoking or managing your weight
- help explain important health information to you or to your doctors

Population Health services are provided whether you're well, have an ongoing health problem or have a terrible health episode. Population Health services are available to you depending on your health risks and need for the service.

Population Health can provide you with a care manager. A care manager can help you get all the care you need. You may be able to have a care manager if you:

- go to the ER a lot, or if you have to go into the hospital a lot, or
- need health care before or after you have a transplant, or
- have a lot of different doctors for different health problems, or
- have an ongoing illness that you don't know how to deal with

To see if you can have a care manager, or if you want to participate in the Population Health services, you (or someone on your behalf) can call your plan.

E2. Sterilization

Sterilization is the medical treatment or surgery that makes you not able to have children. To have this treatment, you must:

- be an adult age 21 or older
- be mentally stable and able to make decisions about your health
- not be in a mental institution or in prison
- fill out a paper that gives your OK. This is called a Sterilization Consent Form. You must fill this out with your provider.

You have to fill the paper out at least 30 days before you have the treatment. But in an emergency like premature delivery or abdominal surgery, you can fill the paper out at least 72 hours before you have the treatment.

E3. Abortion

Abortions may only be covered by TennCare in limited cases, like if you have a physical illness that you could die from without an abortion.

Your doctor must fill out a paper called Certification of Medical Necessity for Abortion.

E4. Hysterectomy

A hysterectomy is a medical surgery that removes reproductive organs. A hysterectomy can be covered when you must have it to fix other medical problems. After a hysterectomy, you won't be able to have children. But, TennCare won't pay for this treatment if you have it just so you won't have children. TennCare pays for this treatment only if it's for a covered reason and medically necessary.

You have to be told in words and in writing that having a hysterectomy means you aren't able to have children. You have to sign a paper called Hysterectomy Acknowledgement Form.

E5. Employment and Community First CHOICES

Employment and Community First CHOICES is for people of all ages who have an intellectual or developmental disability (I/DD). This includes people who have significant disabilities.

Services help people with I/DD gain as much independence as possible. People are supported to live with their family or in the community, not in an institution. Residential services are available for adults with I/DD who don't live with family but need supports where they live.

Employment and Community First CHOICES can help the person with I/DD explore the possibility of working. Services can also help people learn skills for work, find a job, and keep a job. This could be a part-time job, a full-time job or self-employment. Working helps people earn money, learn new skills, meet new people, and play an important role in their communities. Work can also help people stay healthy and build self-confidence.

Other services help people learn and do things at home and in the community that help people achieve their goals. If a person lives at home with their family, the services help the family support the person to become as independent as possible. Services also help people get actively involved in their communities and include peer supports for the person and for their family.

F. Benefits not covered by our plan, Medicare, or TennCare

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and TennCare 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 **Evidence of Coverage**) 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 **Evidence of Coverage**.

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

- Services considered not "reasonable and medically necessary", according Medicare and TennCare 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 **Evidence of Coverage** for more information on clinical research studies. Experimental treatment and items are those that aren't generally accepted by the medical community.
- 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
- Custodial care.

  Custodial Care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of dailiy living, such as bathing or dressing.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- Equipment or supplies that condition the air, heating pads, hot water bottles, wigs and their care, and other primarily non-medical equipment.
- Emergency or urgently needed care received outside of the United States and the U.S. Territories.
- Any non-emergency care received outside of the United States and the U.S. Territories.
- Homemaker services including basic household assistance, such as light housekeeping or light meal preparation
- Immunizations for foreign travel purposes
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- 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
- 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)
- Non-routine dental care
- Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including but not limited to home and car remodeling or modification, and exercise equipment

- Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport)
- Travel or transportation expenses, including but not limited to air or land ambulance services, from a foreign country to the United States.
- Services provided to veterans in Veterans Affairs (VA) facilities.
- Requests for payment (asking the plan to pay its share of the costs) for covered drugs sent after 36 months of getting your prescription filled.
- Transplant Related Travel & Lodging Expenses

  Transplant-related Travel and Lodging expenses are not covered if you receive your transplant at any location in either your state of residence or a state adjacent to your state of residence, or you receive your transplant in the state with the nearest transplant center to you (for your required transplant type) regardless of distance.

  The following types of expenses are not reimbursable:

  - Vehicle rental, purchase, or maintenance/repairs
  - Auto clubs (roadside assistance)
  - Gas
  - Travel by air or ground ambulance (may be covered under your medical benefit).
  - Air or ground travel not related to medical appointments
  - Premium, business class or first class travel
  - Parking fees incurred other than at lodging or medical facility
  - Deposits or furniture rental charges
  - Utilities (if billed separate from the rent payment)
  - Phone calls, newspapers, movie rentals and gift cards
  - Expenses for lodging when staying with a relative or friend
  - Meals, snacks, food or beverages
  - Any eligible lodging expenses exceeding $125/day

  Transplant-related travel and lodging costs are not covered unless you are a UnitedHealthcare Medicare Advantage member at the time you receive your transplant and at the time the transplant-related expense is incurred.

  Transplant-related travel and lodging costs are not covered if you receive your transplant at a location that is not in the plan's Transplant Network for the type of transplant you need.

  Transplant-related travel and lodging costs are not covered for transplant donors.

Chapter 5

Getting your outpatient drugs

Chapter 5

Getting your outpatient drugs

Introduction

This chapter explains rules for getting your outpatient prescription 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 TennCare. **Chapter 6** of this **Evidence of Coverage** tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of this **Evidence of Coverage**. Key terms and their definitions appear in alphabetical order in the last chapter of this **Evidence of Coverage**.

We also cover the following drugs, although they are 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 **Evidence of Coverage**.
- 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 F** "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 TennCare's Terminated Provider List.

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's not 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 bases on criteria conditions before we'll cover it. Refer to **Section C** in this chapter.

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A. Getting your prescriptions filled

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 Customer Service or your care coordinator.

A2. Using your UnitedHealthcare UCard when you fill a prescription

To fill your prescription, **show your UnitedHealthcare UCard** at your network pharmacy. The network pharmacy bills us for our share of the cost your covered drug. You may need to pay the pharmacy a copay when you pick up your prescription.

If you don't have your UnitedHealthcare 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 for our share. **If you can't pay for the drug, contact Customer Service right away.** We'll do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of this **Evidence of Coverage**.
- If you need help getting a prescription filled, contact Customer Service or your care coordinator.

A3. What to do if you change your network pharmacy

If you need help changing your network pharmacy, contact Customer Service or your care coordinator.

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 Customer Service or your care coordinator.

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 Customer Service.
- 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 that are 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 Customer Service or your care coordinator.

A6. Using mail-order services to get your drugs

Our plan's mail-order service allows you to order up to a **100-day supply**.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, please reference your **Provider and Pharmacy Directory** to find the mail service pharmacies in our network. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually, a mail-order prescription arrives **within 10 business days**.

However, sometimes your mail-order may be delayed. If your mail-order is delayed, please follow these steps: 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 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**

   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 do not 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 is 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.

3. **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 of your medication or if 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.

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. The **Provider and Pharmacy Directory** tells you which pharmacies can give you a long-term supply

of maintenance drugs. You can also call your care coordinator or Customer Service for more information.

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.

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 your prescriptions filled as a member of our plan. In these cases, check with Customer Service first to find out if there's a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

We pay for prescriptions filled at an out-of-network pharmacy in the United States in 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 Formulary without restrictions, and are not excluded from Medicare Part D coverage.
- **Coverage when traveling or out of the service area.** If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network preferred mail service pharmacy or through our other network pharmacies. Contact Customer Service to find out about ordering your prescription drugs ahead of time.
- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy is not within reasonable driving distance that provides 24-hour service.
- 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.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to **Chapter 7, Section B** for information on how to ask our plan 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 a network pharmacy.

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 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 **Evidence of Coverage**.

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.

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 TennCare.

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

A brand name drug is a drug that is 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 drugs and work just as well. For more information, call Customer Service.

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:

- Check the most recent **Drug List** we provided electronically.
- Visit our plan's website at **MyUHC.com/CommunityPlan**. The **Drug List** on our website is always the most current one.
- Call Customer Service 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 will pay and if there are alternative drugs on the **Drug List** that could treat the same condition. You can also call your care coordinator or Customer Service.

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 **Evidence of Coverage** 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 TennCare 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 prescription 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 TennCare can't cover the types of drugs listed below.

- Drugs used to promote fertility
- 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
- Drugs used for the treatment of anorexia, weight loss or weight gain
- Outpatient drugs made by a company that says you must have tests or services done only by them

C. Limits on some drugs

For certain prescription 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 make an exception. We may or may not agree to let you use the drug without taking extra steps.

What is a compounded drug?

A compounded drug is created by a pharmacist by combining or mixing ingredients to create a prescription medication customized to the needs of an individual patient.

Does my Part D plan cover compounded drugs?

Generally compounded drugs are non-formulary drugs (not covered) by your plan. You may need to ask for and receive an approved coverage determination from us to have your compounded drug covered. Compounded drugs may be Part D eligible if they meet all of the following requirements:

1. Contains at least one FDA, or Compendia, approved drug ingredient, and all ingredients in the compound (including their intended route of administration) are supported in the Compendia.
2. Does not contain a non-FDA approved or Part D excluded drug ingredient
3. Does not contain an ingredient covered under Part B. (If it does, the compound may be covered under Part B rather than Part D)
4. Prescribed for a medically accepted condition

The chart below explains the basic requirements for how a compound with 2 or more ingredients may or may not be covered under Part D rules, as well as potential costs to you.

Compound Type	Medicare Coverage
Compound containing a Part B eligible ingredient	Compound is covered only by Part B
Compound containing all ingredients eligible for Part D coverage and all ingredients are approved for use in a compound	Compound may be covered by Part D upon approved coverage determination
Compound containing ingredients eligible for Part D coverage and approved for use in a compound, and ingredients excluded from Part D coverage (for example, over the counter drugs, etc.)	Compound may be covered by Part D upon approved coverage determination. However, the ingredients excluded from Part D coverage will not be covered and you are not responsible for the cost of those ingredients excluded from Part D coverage
Compound containing an ingredient not approved or supported for use in a compound	Compound is not covered by Part D. You are responsible for the entire cost

What do I have to pay for a covered compounded drug?

A compounded drug that is Part D eligible may require an approved coverage determination to be covered by your plan. You will pay the non-preferred drug copayment or coinsurance amount for compounded drugs that are approved. No further tier cost share reduction is allowed or available.

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

1. **Limiting use of a brand name drug when a generic version is available**

   Generally, a generic drug works the same as a brand name drug and usually costs less. In most cases, if there's a generic version of a brand name drug available, our network pharmacies give you the generic 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 won't work for you **or** wrote "No substitutions" on your prescription for a brand name drug or told us the medical reason that the generic drug or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.
   - Your copay may be greater for the brand name drug than for the generic 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 Customer Service 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 Customer Service 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 Customer Service 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 **Evidence of Coverage**.

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, **Section C**, 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.

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 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'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 those current members with level of care changes:** There may be unplanned transitions such as hospital discharges (including psychiatric hospitals) or level of care changes (i.e., changing long-term care facilities, exiting and entering a long-term care facility, ending Part A coverage within a skilled nursing facility, or ending hospice

coverage and reverting to Medicare coverage) that can occur anytime. If you are prescribed a drug that is not on our **Drug List** or your ability to get your drugs is restricted in some way, you are required to use the plan's exception process. For most drugs, you may request a one-time temporary supply of at least 30 days to allow you time to discuss alternative treatment with your doctor or to request a **Drug List (formulary)** exception. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 30 day supply.

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Customer Service.

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 Customer Service 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.

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 **Evidence of Coverage**.

If you need help asking for an exception, contact Customer Service or your care coordinator.

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).

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 Customer Service 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 comes on the market that works as well as a brand name drug 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 or will be lower.

  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 **Evidence of Coverage**.

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.

Your prescriber will also know about this change, and can work with you to find another drug for your condition.

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 **Evidence of Coverage**.

Changes to the Drug List that don't affect you during the current 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 increase what you pay for the drug, or limit its use, then the change doesn't affect your use of the for the drug or what you pay for the drug 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.

F. Drug coverage in special cases

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.

To learn more about drug coverage and what you pay, refer to **Chapter 6** of this **Evidence of Coverage**.

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** or visit **MyUHC.com/CommunityPlan** 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 Customer Service.

F3. Drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact that group's benefits administrator. They can help you understand how your current drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be **secondary** to your group coverage. That means your group coverage pays first.

Special note about "creditable coverage":

Each year your employer or retiree group should send you a notice that tells you if your drug coverage for the next calendar year is "creditable."

If the coverage from the group plan is "creditable," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep any notices about creditable coverage, because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from the employer or retiree group's benefits administrator or the employer or union.

F4. 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 **Evidence of Coverage** for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

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.

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 Customer Service or your care coordinator.

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 our 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 **Evidence of Coverage**.)

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 Medicare and TennCare 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 TennCare.

Because you're eligible for TennCare you get Extra Help from Medicare to help pay for your Medicare Part D drugs. We have sent you a separate insert, called the "**Evidence of Coverage** 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 Customer Service and ask for the "LIS Rider."

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."

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

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 Customer Service. You can also find the most current copy of our **Drug List** on our website at **MyUHC.com/CommunityPlan**.
- **Chapter 5** of this **Evidence of Coverage.**
  - 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 Customer Service 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 **Evidence of Coverage** more information about network pharmacies.

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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 prescription 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.

- Payments made for these drugs don't count towards your total out-of-pocket costs.
- 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 TennCare CoverRx Prescription benefit. These drugs are included in the **Drug List**.

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 UnitedHealthcare UCard.**

   Show your UnitedHealthcare UCard® 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 **Evidence of Coverage**.

3. **Send us information about payments others have make for you.**

   Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs.

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 Dual Complete TN-Y001 (HMO-POS D-SNP) Customer Service. 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 Dual Complete TN-Y001 (HMO-POS D-SNP) Customer Service.
- 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 have questions,** please call UHC Dual Complete TN-Y001 (HMO-POS D-SNP) at **1-800-690-1606** (TTY **711**), 8am–8pm: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. For more information, visit **MyUHC.com/CommunityPlan**.

- TennCare Office of Inspector General (OIG) at 1-800-433-3982 or
  P.O. Box 282368
  Nashville, TN 37228
- Tennessee Bureau of Investigation (TBI) Medicaid Fraud unit at 1-800-433-5454 or 901 R.S. Glass Blvd
  Nashville, TN 37216
- Member Fraud: tn.gov/finance/fa-oig/fa-oig-report-fraud.html
- Provider Fraud: tn.gov/tenncare/fraud-and-abuse/program-integrity.html

If you think something is wrong or missing, or if you have any questions, call Customer Service. You can also find answers to many questions on our website: **MyUHC.com/CommunityPlan.** Keep these EOBs. They're an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay for each prescription depends on which stage you're in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, we pay all of the costs of your drugs through December 31, 2026. You begin this stage when you've paid a certain amount of out-of-pocket costs.

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. It costs you the same as a one-month supply. For details on where and how to get a long-term supply of a drug, refer to Chapter 5 of this **Evidence of Coverage** or our **Provider and Pharmacy Directory**.

C2. What you pay

You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Customer Service to find out how much your copay is for any covered drug.

Depending on your TennCare eligibility qualifying you for Extra Help, you may have to pay a cost share for covered Part D drugs. Since you have full TennCare benefits, your Part D cost share with Extra Help will most likely be a $0 copayment. See below for LIS cost sharing related to all levels of Extra Help.

If you qualify for Extra Help from Medicare to help pay for your prescription drug costs, your costs for your Medicare Part D prescription drug will be lower than the amounts listed in the chart below. If you have Medicare and Division of TennCare (Medicaid) you automatically qualify for Extra Help. Members with the lowest income and resources are eligible for the most Extra Help. (Please see your Low Income Subsidy Rider for more information about your actual drug costs.)

For Members that Qualify for Extra Help:

For generic drugs (including drugs treated as generic) either:

- $0
- $1.60
- $5.10

For all other drugs

- $0
- $4.90
- $12.65

You will pay the following for your covered prescription drugs if you DO NOT qualify for "Extra Help" from Medicare to help pay for your prescription drug costs:

Your costs for a one-month supply of a covered Part D drug

	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing** (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing for Covered Drugs[1]	25% coinsurance	25% coinsurance	25% coinsurance

[1]You pay no more than 25% of the total drug cost or a $35 copayment, whichever is lower, for each 1-month supply of Part D covered insulin drugs, even if you haven't paid your deductible, until you reach the Catastrophic Coverage stage where you pay $0.

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

D. Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, we pay a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on the cost-sharing tier the drug is in and where you get it.

D1. Your pharmacy choices

How much you pay for a drug depends on if you get the drug from:

- A network retail pharmacy or
- A network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- An out-of-network pharmacy.

  In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this **Evidence of Coverage** to find out when we do that.
- Our plan's mail-order pharmacy.

To learn more about these choices, refer to **Chapter 5** of this **Evidence of Coverage** and to our **Provider and Pharmacy Directory**

D2. 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 a 100-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this **Evidence of Coverage** or our plan's **Provider and Pharmacy Directory**.

D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Customer Service to find out how much your copay is for any covered drug.

If you qualify for **Extra Help** from Medicare to help pay for your prescription drug costs, your costs for your Medicare Part D prescription drug will be lower than the amounts listed in the chart below.

If you have Medicare and Division of TennCare (Medicaid) you automatically qualify for Extra Help. Members with the lowest income and resources are eligible for the most Extra Help.

(Please see your Low Income Subsidy Rider for more information about your actual drug costs.)

For Members that Qualify for Extra Help:

For generic drugs (including drugs treated as generic) either:

- $0
- $1.60
- $5.10

For all other drugs

- $0
- $4.90
- $12.65

You will pay the following for your covered prescription drugs if you DO NOT qualify for Extra Help from Medicare to help pay for your prescription drug costs.

Your share of the cost when you get a one-month or long-term supply of a covered drug from:

	Standard retail cost-sharing (in-network) (up to a 100-day supply)	**Mail-order cost-sharing** (100-day supply)
Cost-Sharing for Covered Drugs[1]	25% coinsurance Some covered drugs limited to a 30-day supply	25% coinsurance Some covered drugs limited to a 30-day supply

[1]You pay no more than 25% of the total drug cost or a $35 copayment, whichever is lower, for each 1-month supply of Part D covered insulin drugs, even if you haven't paid your deductible, until you reach the Catastrophic Coverage stage where you pay $0.

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

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$2,100**. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

We offer additional drugs that aren't normally covered in a Medicare Drug Plan. Payments made for these drugs don't count toward your out-of-pocket costs.

Your EOB helps you keep track of how much you've paid for your drugs during the year. We let you know if you reach the $2,100 limit. Many people don't reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $2,100 for your drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

F. Your drug costs if your doctor prescribes less than a full month's supply

In some cases, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you're trying a drug for the first time).
- If your doctor agrees, you don't pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. We calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days' supply of the drug, your payment is less than $.05 per day multiplied by 7 days, for a total payment less than $0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
  - Better plan when to refill your drugs,
  - Coordinate refills with other drugs you take, **and**
  - Take fewer trips to the pharmacy.

G. 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 Customer Service for coverage and cost sharing details about specific vaccines.

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

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.

G1. What you need to know before you get a vaccine

We recommend that you call Customer Service if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine and your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider works with us to ensure that you have no upfront costs for a Medicare Part D vaccine.

G2. What you pay for a vaccine covered by Medicare Part D

What you pay for a vaccine depends on the type of vaccine (what you're being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of this **Evidence of Coverage**.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's **Drug List**. You may have to pay a copay for Medicare Part D vaccines. If the vaccine is recommended for adults by an organization called the **Advisory Committee on Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccine.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
   - For most adult Part D vaccines, you'll pay nothing.
   - For other Part D vaccines, you pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.

- You pay nothing to the doctor for the vaccine.
- Our plan pays for the cost of giving you the shot.
- The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.

3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
   - For most adult Part D vaccines, you'll pay nothing for the vaccine itself.
   - For other Part D vaccines, you pay a copay for the vaccine.
   - Our plan pays for the cost of giving you the shot.

Chapter 7

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

Chapter 7

Asking us to pay our share of 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 **Evidence of Coverage**.

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A. Asking us to pay for your 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 Dual Complete TN-Y001 (HMO-POS D-SNP) providers to bill you for these services. We pay our providers directly, and we protect you from any charges.

If you get a bill for the full cost of health care or drugs, don't pay the bill and send the bill to us. To send us a bill, refer to **Section B**.

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid more than your share of the cost; 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 TennCare we can't pay you back, but the provider will. Customer Service or your care coordinator can help you contact the provider's office. Refer to the bottom of the page for the Customer Service phone number.
- If we don't cover the services or drugs, we'll tell you.

Contact Customer Service or your care coordinator if you have any questions. If you don't know what you should've paid, or 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 for our share of the cost. 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 more than your share of the cost for the Medicare service, we'll figure out how much you owed and pay you back for our share of the cost.
   - 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 UnitedHealthcare 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 Customer Service** or your care coordinator 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.

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 for our share of the cost.
   - Refer to **Chapter 5** of this **Evidence of Coverage** 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 UnitedHealthcare UCard with you**

   If you don't have your UnitedHealthcare 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 UnitedHealthcare UCard.
   - Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
   - 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 Medicare Part D 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 **Evidence of Coverage**).
     - 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 **Evidence of Coverage**).
   - 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 our share of 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 Customer Service immediately using the number on your UCard. 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 Customer Service 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 Evidence of Coverage, 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 Evidence of Coverage.
- 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'll review your request and decide whether the service or drug should be covered. This is called making a coverage decision. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

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 the service or drug should be covered, we pay for our share of the cost of 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 **Evidence of Coverage**.

B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services or call us. 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. You must submit your Part C (medical) claim to us within 12 months** of the date you received the service, item, or drug. **You must submit your Part D (prescription drug) claim to us within 36 months** of the date you received the service, item, or drug.

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 Customer Service 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:

UnitedHealthcare
P.O. Box 5290
Kingston, NY 12402-5290

Medical claims payment requests:

UnitedHealthcare
P.O. Box 5290
Kingston, NY 12402-5290

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 our share of the cost for it. If you already paid for the service or drug, we'll mail you a check for our share of the cost. 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 **Evidence of Coverage** explains the rules for getting your services covered. **Chapter 5** of this **Evidence of Coverage** explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for our share of the cost of 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**.

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 **Evidence of Coverage**:

- 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 **Evidence of Coverage**.

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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 Customer Service. 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 Customer Service or write to:

  UHC Dual Complete TN-Y2 (HMO-POS D-SNP) Customer Service Department
  P.O. Box 30769
  Salt Lake City, UT 84130-0769

  We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you.
- If English isn't your first language, you can ask for an interpreter when you get your care. This is a free service for you. **Before your appointment, call us or your provider** so you can get help with language services.
- You can also check in our **Provider Directory** to find doctors who speak other languages. For more information contact Customer Service or visit the website at **myUHC.com/CommunityPlan**.
- You can also get free help to communicate with your doctor like a sign language interpreter, writing notes, or a story board. **Before your appointment, call us or your provider** to get this help.
- Si el inglés no es su primer idioma, puede pedir un intérprete para sus consultas. Éste es un servicio gratuito para usted. **Antes de su cita, llámenos o llame a su proveedor** para que pueda recibir ayuda con servicios lingüísticos.
- También puede consultar nuestro **Directorio de Proveedores** para buscar médicos que hablan otros idiomas.
- También puede recibir ayuda gratuita para comunicarse con su doctor, como un intérprete de lenguaje de señas, escribir notas o un guión gráfico. **Antes de su cita, llámenos o llámenos a su proveedor** para recibir esta ayuda.

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.
- TennCare, Office of Civil Rights Compliance at 1-855-857-1673 (TRS 711) To file a complaint or learn more about your rights visit tn.gov/tenncare/membersapplicants/civil-rights-compliance.html.
- U.S. Department of Health & Human Services Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. To file a complaint or learn more about your rights visit: hhs.gov/ocr/complaints/index.html.

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 **Evidence of Coverage**.
  - Call your care coordinator or Customer Service 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 **Evidence of Coverage**.

Chapter 9 of this **Evidence of Coverage** 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.

How to Receive Care After Hours

If you need to talk to or see your Primary Care Provider after the office has closed for the day, call your Primary Care Provider's office. When the on-call physician returns your call he or she will advise you on how to proceed.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

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."

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. TennCare exchanges PHI under restricted and limited use to process and pay claims, in accordance with federal regulations.

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. We may charge you a fee for making a copy of your medical 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 Customer Service.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

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

Effective January 1, 2024

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

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

By law, we must follow the terms of our current notice.

HI is information about your health or medical services. We have the right to make changes to this notice of privacy practices. If we make important changes, we will notify you by mail or e-mail. We will also post the new notice on our website. Any changes to the notice will apply to all HI we have. We will notify you of a breach of your HI.

How We Collect, Use, and Share Your Information

We collect, use and share your HI with:

- You or your legal or personal representative.
- Certain Government agencies. To check to make sure we are following privacy laws.

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

- **For Payment.** To process payments and pay claims. For example, we may tell a doctor whether we will pay for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment or Managing Care.** To help with your care. For example, we may share your HI with a hospital you are in, to help them provide medical care to you.
- **For Health Care Operations.** To run our business. For example, we may talk to your doctor to tell him or her about a special disease management or wellness program available to you. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** If you receive health insurance through your employer, we may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.

- **For Underwriting Purposes.** To make health insurance underwriting decisions. We will not use your genetic information for underwriting purposes.
- **For Reminders on Benefits or Care.** We may send reminders about appointments you have and information about your health benefits.
- **For Communications to You.** We may contact you about your health insurance benefits, healthcare or payments.

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

- **As Required by Law.** To follow the laws that apply to us.
- **To Persons Involved with Your Care**. A family member or other person that helps with your medical care or pays for your care. This also may be to a family member in an emergency. This may happen if you are unable to tell us if we can share your HI or not. If you are unable to tell us what you want, we will use our best judgment. If allowed, after you pass away, we may share HI with family members or friends who helped with your care or paid for your care.
- **For Public Health Activities.** For example, to prevent diseases from spreading or to report problems with products or medicines.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with certain entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings**, for example, to answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** To public health agencies or law enforcement, for example, in an emergency or disaster.
- **For Government Functions.** For military and veteran use, national security, or certain protection services.
- **For Workers' Compensation.** If you were hurt at work or to comply with employment laws.
- **For Research.** For example, to study a disease or medical condition. We also may use HI to help prepare a research study.
- **To Give Information on Decedents.** For example, to a coroner or medical examiner who may help identify the person who died, why they died, or to meet certain laws. We also may give HI to funeral directors.

- **For Organ Transplant.** For example, to help get, store or transplant organs, eyes or tissues.
- **To Correctional Institutions or Law Enforcement.** For persons in custody, for example: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates.** To give you services, if needed. These are companies that provide services to us. They agree to protect your HI.
- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
  1. Alcohol and Substance Use Disorder
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

We will only use or share your HI as described in this notice or with your written consent. We will get your written consent to share psychotherapy notes about you, except in certain cases allowed by law. We will get your written consent to sell your HI to other people. We will get your written consent to use your HI in certain marketing mailings. If you give us your consent, you may take it back. To find out how, call the phone number on your UCard.

Your Rights

You have the following rights for your medical information.

- **To ask us to limit** our use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others that help with your care or pay for your care. We may allow your dependents to ask for limits. We will try to honor your request, but we do not have to do so. Your request to limit our use or sharing must be made in writing.
- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request as allowed by state and federal law. We take verbal requests but may ask you to confirm your request in writing. You can change your request. This must be in writing. Mail it to the address below.

- **To see or get a copy of certain HI.** You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete you can ask to change it. You must ask in writing. You must give the reasons for the change. We will respond to your request in the time we must do so under the law. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of when we shared your HI in the six years prior to your request. This will not include when we shared HI for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website.
- In certain states, you may have the right to ask that we delete your HI. Depending on where you live, you may be able to ask us to delete your HI. We will respond to your request in the time we must do so under the law. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

Using Your Rights

- **To Contact your Health Plan.** If you have questions about this notice, or you want to use your rights, call the phone number on your UCard. Or you may contact the UnitedHealth Group Call Center at **1-800-690-1606**, or TTY/RTT **711**.
- **To Submit a Written Request.** Mail to:
  United Healthcare Privacy Office
  MN017-E300
  PO Box 1459
  Minneapolis MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

[1]This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to **uhc.com/privacy/entities-fn-v2**.

FINANCIAL INFORMATION PRIVACY NOTICE

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

Effective January 1, 2024

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

Information We Collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and Security

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

Questions About This Notice

Please call the toll-free member phone number on your UCard or contact the UnitedHealth Group Customer Call Center at **1-800-690-1606**, or TTY/RTT **711**.

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

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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 Customer Service. 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 Customer Service:

- 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 **Evidence of Coverage**) and drugs (refer to **Chapters 5 and 6** of this **Evidence of Coverage**) 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 **Evidence of Coverage**), including asking us to:
  - put in writing why something isn't covered
  - change a decision we made
  - pay for a bill you got

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 **Evidence of Coverage**.

F. Your right to leave our 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 **Evidence of Coverage**:
  - For more information about when you can join a new MA or prescription drug benefit plan.
  - For information about how you'll get your TennCare benefits if you leave our plan.

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.

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 **Evidence of Coverage** tells how to ask us for a coverage decision.

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 that 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 Customer Service 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 Customer Service for more information.

G3. What to do if your instructions aren't 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 your state Department of Health.

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of this **Evidence of Coverage** 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 Customer Service to get this information.

You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

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 **Evidence of Coverage** — or you want more information about your rights, you can call:

- Customer Service.
- The TN SHIP program at 1-877-801-0044. For more details about TN SHIP, refer to **Chapter 2**.
- The Ombudsperson Program 1-877-236-0013 or 615-532-3893 (TDD). For more details about this program, refer to **Chapter 2** of this **Evidence of Coverage**.

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 medicare.gov/publications/11534-medicare-rights-and-protections.pdf.)

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 Customer Service.

- **Read this Evidence of Coverage** 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 **Evidence of Coverage**. 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 **Evidence of Coverage**.
- **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 Customer Service if you have other coverage.
- **Tell your doctor and other health care providers** that you're a member of our plan. Show your UnitedHealthcare 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.
- **Medicare Part A and Medicare Part B premiums.** For most UHC Dual Complete TN-Y001 (HMO-POS D-SNP) members, TennCare 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 your care coordinator or Customer Service.
  - **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 **Evidence of Coverage** 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 prescription drug plan in your new location. We can tell you if we have a plan in your new area.
- Tell Medicare and TennCare your new address when you move. Refer to **Chapter 2** of this **Evidence of Coverage** for phone numbers for Medicare and TennCare
- **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 your care coordinator or Customer Service for help if you have questions or concerns.**

I1. Estate Recovery

Estate Recovery is the way TennCare collects money from the estates of people who received TennCare long-term services and supports and passed away. TennCare is required by federal law to recoup (get back) these payments after the death of the member. This is referred to as "estate recovery." The kinds of care that must be paid back are listed below.

Your "estate" is the property, belongings, money, and other assets that you own at the time of your death. Estate recovery is using the value of your property after you die to pay TennCare back for care you got. Keep reading to find out who has to pay TennCare back and how much your estate will have to pay back.

TennCare can't ask for the money back until **after** your death. TennCare can't ask for more money back than what was paid for. TennCare can't ask your family to pay for your care out of their own pockets.

If the value of all of your assets at the time of your death is less than TennCare's bill, TennCare is only allowed to get the value of your assets and no more. For example, if the only thing that you own at the time of your death is a home valued at $50,000 but TennCare has a bill of $75,000, then TennCare is only allowed to collect $50,000. TennCare can't ask your family to pay for the remaining amount.

I2. Who has to pay TennCare back for their care?

TennCare **must** ask to be paid back for money it spent on your care if you're age 55 and older and got care in a nursing home or intermediate care facility for individuals with intellectual disabilities ICF/IID, home care — called home and community-based services or HCBS, home health or private duty nursing.

I3. What kinds of care must be paid back to TennCare?

TennCare **must** ask to be repaid for:

- Care in a nursing home or ICF/IID.
- Home care, known as home and community-based services or HCBS.
- Home Health or private duty nursing.
- Hospital care and drugs related to your long-term care services.

I4. How much will your estate have to pay TennCare back for your care?

To provide long-term care, TennCare contracts with a health insurance company (also called a "managed care organization" or "MCO"). When someone receives TennCare, TennCare pays a monthly premium to the insurance company. The monthly premium is called a "capitation rate." In return, the insurance company pays the health care provider (like a nursing facility or other entity providing long-term care in the home/community) for the person's care. Under federal law, TennCare must ask to be paid back the premium payment it made to the insurance company for you.

The premium payment made to the insurance company is the same each month, no matter what services you actually receive that month. The premium payment can also be different depending on what type of long-term care you have and the part of the state you live in.

I5. TennCare may not have to get the money back from your estate if:

- You don't have money, property, or other assets when you die or
- The things you left can't be used to pay people you owe through probate court. An example is life insurance money.

I6. What if I sell or give away my home while I am receiving TennCare?

Then you must tell TennCare that you sold or gave away your home, which can affect your TennCare eligibility. You must also tell TennCare about any transfer made five years before you received TennCare. If you don't tell them about the transfer, they can have the transfer set aside and ask to be paid back from your estate, family member(s), or any other person that participated in the transfer.

I7. What are the reasons that TennCare can delay estate recovery?

In some situations, estate recovery is delayed or "deferred," which means that TennCare won't go after your estate until a later date. TennCare defers estate recovery for an individual's estate when:

- You have a surviving husband or wife. TennCare can't collect money from your estate until the death of your husband or wife.
- You have a child that's under the age of 21. TennCare can't collect money from your estate until your child is over the age of 21.
- You have a blind or permanently disabled child. TennCare can't recover until the death of the disabled child.
- You have a son or daughter whose care kept you out of the nursing home for **at least** two years. TennCare can't collect money from your estate until your son or daughter no longer lives at the property.
- Your brother or sister whose care kept you out of the nursing home lived in your home for a year **before** you got nursing home or home care. If the brother or sister passes away or no longer resides at the property, then the deferral no longer exists.
- If the property is the family's only income, like a family farm.

I8. How will your family find out if your estate owes money to TennCare?

To find out if the estate owes money to TennCare, your family or representative must submit a Request for Release Form to TennCare in one of three ways:

Get the Request for Release online at: tn.gov/content/dam/tn/tenncare/documents/releaseform.pdf

- Get the Request for Release from the Probate Court Clerk's office by asking for a "Request for Release from Estate Recovery".
- Get the Request for Release from TennCare by sending a fax to: 615-413-1941 or a letter to
  Division of TennCare Estate Recovery Unit
  310 Great Circle Rd. 4th Floor
  Nashville, TN 37243

I9. What if you do have to pay TennCare money from your estate?

Your family or representative has many options if there's a TennCare claim:

- They can pay the TennCare claim from your remaining belongings.
- Your estate can be admitted to "Probate." When this happens, a Court will appoint someone known as an administrator (or if you have a will this person is known as an executor) to sell your property, to pay any debts that you might have had while alive and then give your heirs the remaining property/money if there's anything left. Your family or TennCare can request that an administrator be appointed for your estate.

- They may apply for a deferral of Estate Recovery.

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.**

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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.

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.

B. Where to get help

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 Tennessee State Health Insurance Assistance Program (TN SHIP)

You can call the TN SHIP program. TN SHIP counselors can answer your questions and help you understand what to do about your problem. TN SHIP isn't connected with us or with any insurance company or health plan. TN SHIP has trained counselors in every county, and services are free. The TN SHIP phone number is 1-877-801-0044.

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 (medicare.gov).

Help and information from TennCare

Call TennCare 1-855-259-0701 or 1-800-848-0298 (TTY).

C. Understanding Medicare and TennCare complaints and appeals in our plan

You have Medicare and TennCare. Information in this chapter applies to **all** your Medicare and TennCare benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and TennCare processes.

Sometimes Medicare and TennCare processes can’t be combined. In those situations, you use one process for a Medicare benefit and another process for a TennCare benefit. **Section F4** explains these situations.

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. Refer to **Section E**, "Coverage decisions and appeals."
No. My problem isn't about benefits or coverage. Refer to **Section K**, "How to make a complaint."

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**.

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 **Evidence of Coverage**).

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 TennCare If you disagree with this coverage decision, you can make an appeal.

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 TennCare 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 your problem is about coverage of a service or item covered by both Medicare and TennCare, the letter will give you information regarding both types of 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.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Customer Service** at the numbers at the bottom of the page.
- Tennessee State Health Insurance Assistance Program (TN SHIP) at 1-877-801-0044.
- **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 Customer Service 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 cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. **You must give us a copy of the signed form.**

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 Customer Service at the numbers at the bottom of the page.

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 **Evidence of Coverage** 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 prescription drugs differ from rules for medical services and items.

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.

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: **1-800-690-1606**, TTY: **711**.
- Faxing: 1-888-950-1169.
- Writing:
  UnitedHealthcare Customer Service Department
  P.O. Box 30769, Salt Lake City, UT 84130-0769

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 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 F3**).

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.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at **1-800-690-1606**, TTY **711**.

Ask for a standard appeal or a fast appeal in writing or by calling us at **1-800-690-1606**, TTY **711**.

- 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 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 did not get, 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 TennCare service or item, a Level 2 Fair hearing will be forwarded automatically. In Tennessee a Fair Hearing is called an appeal.
- **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 TennCare service or item, a Level 2 Fair hearing will be forwarded automatically. In Tennessee a Fair Hearing is called an appeal.

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 of making decision, no longer than 30 days from the date we get the request for reconsideration/appeal, 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 TennCare service or item, a Level 2 Appeal will be forwarded automatically.

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, TennCare, 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 TennCare usually covers, a Level 2 Appeal will be forwarded automatically. 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 TennCare** may cover, you automatically get a Level 2 Appeal with the IRO. The case will be forwarded automatically.

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 TennCare, your benefits for that service, the case will be automatically forwarded.

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 a 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 TennCare usually covers, or that's covered by both Medicare and TennCare

A Level 2 Appeal for services that TennCare usually covers is a Fair Hearing with the state. Your Level 2 Fair hearing will be automatically forwarded. The letter you get from us tells you where to submit your request for a Fair Hearing.

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your **case file. You have the right to ask us for a free copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

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

- For the fast appeal the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- For the standard appeal if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization 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 receive the independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date we receive the independent review organization's decision for **expedited requests**.
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Medicare Part B prescription drug **within 72 hours** after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests**.
- **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called upholding the decision or turning down your appeal.) In this case, the independent review organization will send you a letter:

Explaining its decision.

- Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.

Telling you how to file a Level 3 appeal.

- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.
  - The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

You can file an appeal by calling TennCare Member Medical Appeals at 1-800-878-3192.

- If you have an emergency and your health plan agrees that you do, you will get an **expedited** appeal. An expedited appeal will be decided in about one week. It could take longer if your health plan needs more time to get your medical records.
- If you are already getting care, you may be able to keep getting it during your appeal. To keep getting care during your appeal, **all** of these things must be true:
  - You must appeal by the date your care will stop or change or within 10 days of the date on the letter from your health plan (whichever date is later).
  - You must say in your appeal that you want to keep getting the care during the appeal.
  - The appeal must be for the **kind** and **amount** of care you've been getting that has been stopped or changed.
  - You must have a doctor's order for the care (if one is needed).
  - The care must be something that TennCare still covers.

IMPORTANT: What if you want to keep getting care **during** your appeal and you lose your appeal? You may have to pay TennCare back for the care you got during your appeal.

What does TennCare do when you appeal about a health care problem?

- When TennCare gets your appeal, they'll send you a letter that says they got your appeal. If you asked to keep getting your care during your appeal, it will say if you can keep getting your care. If you asked for an emergency appeal, it will say if you can have an emergency appeal.
- If TennCare needs more facts to work your appeal, you'll get a letter that says what facts they still need. You should give TennCare all of the facts that they ask for as soon as possible. If you don't, your appeal may end.
- TennCare must decide a regular appeal in 90 days. If you have an emergency appeal, they'll try to decide your appeal in about one week (unless they need more time to get your medical records).

What happens at a fair hearing about health care problems?

- Your hearing can be by phone or in person. The different people who may be at your hearing include:
  - An administrative judge
  - A TennCare lawyer
  - A witness for TennCare (someone like a doctor or nurse from TennCare)
- You can talk for yourself. Or, you can bring someone else, like a friend or a lawyer, to talk for you.

- During the hearing, you get to tell the judge facts and proof about your health and medical care. The judge will listen to everyone's side.

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.

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.

We can't reimburse you directly for a TennCare service or item. If you get a bill that's more than your copay, for TennCare 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 that health care provider if you followed the rules for getting services or item.

If you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a TennCare service or item you paid for, you'll ask us to make this 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. For more information, refer to **Chapter 7** of this **Evidence of Coverage**.

G. 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 TennCare 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 **Evidence of Coverage** for more information about a medically accepted indication.

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 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 want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask 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**

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."**

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**
   - You can't get an exception to the required copay amount for the drug.
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 **Evidence of Coverage** 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.
- If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.

G3. Important things to know about asking for an exception

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.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling **1-800-690-1606**, TTY **711**, 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 **Evidence of Coverage**.
- 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.

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 **1-800-690-1606**, TTY **711**, 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.

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.

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 **Evidence of Coverage**.

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.

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 Customer Service 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 Customer Service 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 cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-maim.

H2. Making a Level 1 Appeal

To ask 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 Tennessee the QIO is ACENTRA. Call them at 1-888-317-0751. 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,** if 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 Customer Service at the numbers at the bottom of the page.
- Call the Tennessee State Health Insurance Assistance Program (TN SHIP) at 1-877-801-0044.

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 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 is 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 Customer Service 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 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 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.

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 1-888-317-0751.

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 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 must pay you back for hospital care costs since 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.

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.

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.

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 Customer Service at the numbers at the bottom of the page.
  - Call the TennCare Medical Appeal office at 1-800-878-3192 or 1-866-771-7042 (TTY).
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of this **Evidence of Coverage** 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.
- If you miss the deadline for contacting the QIO, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4**.

The legal term for the written notice is **"Notice of Medicare Non-Coverage"**. To get a sample copy, call Customer Service 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 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.

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 1-888-317-0751.

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.

J. Taking your appeal beyond Level 2

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.

J2. Additional TennCare appeals

You also have other appeal rights if your appeal is about services or items that TennCare 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.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be appropriate for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been 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** 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.

K. How to make a complaint

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 customer service. 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 didn't respect your right to privacy or shared confidential information about you.

Complaint	Example
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. • For these types of complaints contact TennCare's Office of Civil Rights Compliance at tn.gov/tenncare/members-applicants/civil-rights-compliance or toll free at 855-857-1673. For TRS dial 711
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Customer Service, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office isn't clean.
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 the Long Term Care Ombudsman Office at:

Tennessee Commission on Aging and Disability
502 Deaderick Street, 9th Floor
Nashville, TN 37243-0860

Tel: 615-253-5412

Fax: 615-741-3309

Toll Free: 877-236-0013

TDD: 615-532-3893

The legal term for a "complaint" is a **"grievance."**

The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Customer Service at **1-800-690-1606**, TTY **711**. 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, Customer Service will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.

If something kept you from filing your complaint (you were sick, we provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days. We will address your complaint as quickly as possible as but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.

If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. If we do not accept your grievance in the whole or in part, our written decision will explain why it was not accepted, and will tell you about options you may have. The address and fax numbers for filing complaints are located in Chapter 2 under How to contact us when you are making a complaint about your medical care or for Part D prescription drug complaints, How to contact us when you are making an appeal or complaint about your Part D prescription drugs.

Whether you call or write, you should contact Customer Service right away. You can make the complaint at any time after you had the problem you want to complain about.

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.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: medicare.gov/my/medicare-complaint. You do not need to file a complaint with UHC Dual Complete TN-Y001 (HMO-POS D-SNP) 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 can call 1-877-486-2048. The call is free.

Get services without being treated in a different way because of race, color, national origin (like your birthplace), language, sex, age, religion, disability, or other groups protected by the civil rights laws. You have a right to report or file a written complaint if you think you have been treated differently. Being treated differently means you've been discriminated against. If you complain, you have the right to keep getting care without fear of bad treatment from DSNP, providers, or TennCare. To file a complaint or learn more about your rights visit:

TennCare's Office of Civil Rights Compliance at:

tn.gov/tenncare/members-applicants/civil-rights-compliance

Or call toll free at: 855-857-1673 (TRS 711)

Office for Civil Rights (OCR)

You can make a complaint to the U.S. 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 hhs.gov/ocr for more information.

You may also have rights under the Americans with Disability Act (ADA). You can contact the U.S. Department of Justice's Civil Rights Division at ada.gov/file-a-complaint or mail them at:

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, NW
Washington, DC 20530

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 **Evidence of Coverage**.

In Tennessee, the QIO is called ACENTRA. The phone number for ACENTRA is 1-888-317-0751.

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 TennCare programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this **Evidence of Coverage**.

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H. How to get more information about ending your plan membership ... 252

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 have TennCare you have some choices to end your membership with our plan any month of the year.

In addition, 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 TennCare 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**.
- TennCare services in **Section C2**.

You can get more information about how you can end your membership by calling:

- **Customer Service** 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), TN SHIP at 1-877-801-0044 (TTY 711).

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of this **Evidence of Coverage** for information about drug management programs.

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 **Customer Service** 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 in Section C.

C. How to get Medicare and TennCare services separately

You have choices about getting your Medicare and TennCare services if you choose to leave our plan.

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 TennCare 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) plan, if you qualify.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 423-698-0802. If you need help or more information: • Call the TN SHIP at 1-877-801-0044 (TTY 711). In Tennessee, the SHIP is called TN SHIP. **OR** Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. Your TennCare enrollment may not be affected by this change.
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. If you need help or more information: • Call the TN SHIP at 1-877-801-0044 (TTY 711). In Tennessee, the SHIP is called TN SHIP. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. Your TennCare enrollment may not be affected by this change.

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 TN SHIP at 1-877-801-0044, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local TN SHIP office in your area, please visit tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the TN SHIP at 1-877-801-0044 (TTY 711). In Tennessee, the SHIP is called TN SHIP. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. Your TennCare enrollment may not be affected by this change.
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. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 423-698-0802. If you need help or more information: • Call the TN SHIP at 1-877-801-0044 (TTY **711**). In Tennessee, the SHIP is called TN SHIP. **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. Your TennCare enrollment may not be affected by this change.

C2. Your TennCare services

To get different TennCare services within the first 90 days of your approval, call TennCare Member Medical Appeals at 1-800-878-3192 for free.

Tell them you just got your TennCare and you want to change your health plan. After 90 days, it's harder to change your health plan. Call us at 1-855-259-0701 for free. We'll help you fix the problem.

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 TennCare coverage begins. During this time, you keep getting your prescription 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 Dual Complete TN-Y001 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.

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 TennCare. Our plan is for people who qualify for both Medicare and TennCare.
- If you move out of our service area.
- If you're away from our service area for more than six months.
  - If you move or take a long trip, call **Customer Service** 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'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.

We can make you leave our plan for the following reasons only if we get permission from Medicare and TennCare 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 UnitedHealthcare UCard to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

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.

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 **Evidence of Coverage** for information about how to make a complaint.

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 **Customer Service** 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 **Evidence of Coverage**.

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A. Notice about laws

Many laws apply to this **Evidence of Coverage**. These laws may affect your rights and responsibilities even if the laws aren't included or explained in this **Evidence of Coverage**. The main laws that apply are federal laws about the Medicare and TennCare programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, mental 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 TennCare's Office of Civil Rights Compliance. To learn more about your rights or to file a complaint go to: tn.gov/tenncare/members-applicants/civil-rights-compliance.html. Or call 855-857-1673 (TRS 711).
- 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 **hhs.gov/ocr** for more information.
- If you have a disability and need help accessing health care services or a provider, call Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

C. Notice about Medicare as a second payer and TennCare 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 TennCare is the payer of last resort. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

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.

E. Member liability

In the event we fail to reimburse 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 non-covered services except for the following eligible expenses:

- Emergency services
- Urgently needed services
- Out-of-area and routine travel dialysis (must be received in a Medicare Certified Dialysis Facility within the United States)
- Post-stabilization services

If you enter into a private contract with a provider, neither the plan nor Medicare will pay for those services.

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.

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.**

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, providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage 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 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.

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.

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.

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 Evidence of Coverage or be used in defense of a legal action unless it is contained in a written application.

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

M. 2026 Enrollee Fraud & Abuse Communication

2026 Enrollee Fraud & Abuse Communication

How you can fight health care 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 Dual Complete TN-Y001 (HMO-POS D-SNP) Customer Service at **1-800-690-1606** (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.

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.

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 Customer Service. 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 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 basic or

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 wellbeing. 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

You may wish to 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.

The fitness benefit varies by plan/area and may not be available on all plans. The fitness benefit includes a standard fitness membership. The information provided is for informational purposes only and is not medical advice. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Gym network may vary in local market and plan.

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

Introduction

This chapter includes key terms used throughout this **Evidence of Coverage** 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 Customer Service.

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 **Evidence of Coverage** 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 is 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 is 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 coordinator: 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."

Catastrophic coverage stage: The stage in the Medicare Part D drug benefit where our plan pays all costs of your Part D drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the year. You pay nothing.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of this **Evidence of Coverage** 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.

Copay: A fixed amount you pay as your share of the cost each time you get certain drugs. For example, you might pay $2 or $5 for a drug.

Cost-sharing: Amounts you have to pay when you get certain drugs. Cost-sharing includes copays.

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 **Evidence of Coverage** explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all 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.

Daily cost-sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply.

Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7-day supply of the drug, your payment is less than $0.05 per day multiplied by 7 days, for a total payment less than $0.35.

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 people who are eligible for both Medicare and 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 (and if you're a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that is 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.

Evidence of Coverage 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.

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 coordinators 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 Customer Service if you get any bills you don't understand.

Because we pay the entire cost for your services, you **don't** owe any cost-sharing. Providers shouldn't bill you anything for these services.

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.

Initial coverage stage: The stage before your total Medicare Part D drug expenses reach $2,100. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

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 Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and 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"

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 of 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-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-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 TennCare. 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. TennCare 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 **Evidence of Coverage** for more information.

Member (member of our plan, or plan member): A person with Medicare and TennCare 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.

Customer Service: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this **Evidence of Coverage** for more information about Customer Service.

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 **Evidence of Coverage**.

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 **Evidence of Coverage** 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 is 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 **Evidence of Coverage** 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 **Evidence of Coverage** 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 **Evidence of Coverage**.

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 TennCare 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 **Evidence of Coverage** 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 **Evidence of Coverage**.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of this **Evidence of Coverage** 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 TennCare service that we won't approve, or we won't continue to pay for a TennCare 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.

TennCare: This is the name of Tennessee Medicaid program. TennCare 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.

- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you cannot get to them because given your time, place, or circumstances, it is not possible, or it is unreasonable to obtain services from network providers (for example when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).

UHC Dual Complete TN-Y001 (HMO-POS D-SNP) Customer Service:

Call **1-800-690-1606**
Calls to this number are free. 8am–8pm: 7 Days Oct–Mar; M–F Apr–Sept. Customer Service also has free language interpreter services available for non English speakers.

TTY **711**
Calls to this number are free. 8am–8pm: 7 Days Oct–Mar; M–F Apr–Sept.

Write: **P.O. Box 30769, Salt Lake City, UT 84130-0769**

myUHC.com/CommunityPlan

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, Section C of the **Evidence of Coverage**.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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