Evidence of Coverage 2026

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

myUHC.com/CommunityPlan

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January 1 – December 31, 2026

Evidence of Coverage for 2026

Your Medicare Health Benefits and Services and Drug Coverage as a Member of our plan

This document gives the details of your Medicare and Medicaid health and drug coverage from January 1 – December 31, 2026.

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

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

- Our plan premium and cost-sharing
- Our medical and drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Customer Service at 1-844-368-7151 (TTY users call 711). Hours are 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept. This call is free.

This plan, UHC Dual Complete VA-Y001 (HMO-POS D-SNP), is insured through UnitedHealthcare Insurance Company or one of its affiliates. (When this **Evidence of Coverage** says "we," "us," or "our," it means UnitedHealthcare. When it says "plan" or "our plan," it means UHC Dual Complete VA-Y001 (HMO-POS D-SNP).)

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at 1-844-368-7151 for additional information (TTY users should call 711). Hours are 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

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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.

OMB Approval 0938-1051 (Expires: August 31, 2026)

2026 Evidence of Coverage
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Chapter 1:
Get started as a member

Section 1 You're a member of UHC Dual Complete VA-Y001 (HMO-POS D-SNP)

Section 1.1 You're enrolled in UHC Dual Complete VA-Y001 (HMO-POS D-SNP), which is a Medicare Special Needs Plan

You're covered by both Medicare and Medicaid:

- **Medicare** is 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 (kidney failure).
- **Medicaid** is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You've chosen to get your Medicare and Medicaid health care and your drug coverage through our plan, UHC Dual Complete VA-Y001 (HMO-POS D-SNP). Our plan covers all Part A and Part B services. However, cost-sharing and provider access in our plan differs from Original Medicare.

UHC Dual Complete VA-Y001 (HMO-POS D-SNP) is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. UHC Dual Complete VA-Y001 (HMO-POS D-SNP) is designed for people who have Medicare and are entitled to help from Medicaid. The name of your Medicaid plan is Cardinal Care.

Because you get help from Medicaid with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance), you may pay nothing for your Medicare services. Medicaid may also provide other benefits by covering health care services and prescription drugs that aren't usually covered under Medicare. You'll also get "Extra Help" from Medicare to pay for the costs of your Medicare drugs. UHC Dual Complete VA-Y001 (HMO-POS D-SNP) will help you manage all these benefits, so you get the health services and payment help that you're entitled to.

UHC Dual Complete VA-Y001 (HMO-POS D-SNP) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. "Point-of-Service" means you can use providers outside the plan's network for an additional cost. (Go to Chapter 3, Section 2.3 for information about using the Point-of-Service option.) Like all Medicare Advantage plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Virginia Medicaid program to coordinate your Medicaid benefits. We're pleased to provide your Medicare and Medicaid coverage, including drug coverage.

Section 1.2 Legal information about the Evidence of Coverage

This **Evidence of Coverage** is part of our contract with you about how UHC Dual Complete VA-Y001 (HMO-POS D-SNP) covers your care. Other parts of this contract include your enrollment form, the **List of Covered Drugs (Formulary)**, and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

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

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of the plan after December 31, 2026. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) and Virginia Department of Medical Assistance Services must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare and Virginia Department of Medical Assistance Services renew approval of our plan.

Section 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You are eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.3). People who are incarcerated aren’t considered to be living in the geographic service area, even if they are physically located in it.
- You’re a United States citizen or are lawfully present in the United States
- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who get certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and Full Medicaid Benefits.

Note: If you lose your eligibility but can reasonably be expected to regain eligibility within 6 months, then you're still eligible for membership. (Chapter 4, Section 2.1 tells you about coverage during a period of deemed continued eligibility).

Section 2.2 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year.

You can enroll in this plan if you are in one of these Medicaid categories:

- **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance and copayment amounts for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).

- **Specified Low-Income Medicare Beneficiary (SLMB+):** Medicaid pays your Part B premium and provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from your state Medicaid agency in paying your Medicare cost share amounts. Generally your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost sharing when a service or benefit is not covered by Medicaid.

- **Full Benefits Dual Eligible (FBDE)**: Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from the State Medicaid Office in paying your Medicare cost share amounts. Generally your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost sharing when a service or benefit is not covered by Medicaid.

Section 2.3 Plan service area for UHC Dual Complete VA-Y001 (HMO-POS D-SNP)

Our plan is only available to individuals who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these counties in Virginia: Accomack, Albemarle, Alexandria City, Alleghany, Amelia, Amherst, Appomattox, Arlington, Augusta, Bath, Bedford, Bland, Botetourt, Bristol City, Brunswick, Buchanan, Buckingham, Buena Vista City, Campbell, Caroline, Carroll, Charles City, Charlotte, Charlottesville City, Chesapeake City, Chesterfield, Clarke, Colonial Heights City, Covington City, Craig, Culpeper, Cumberland, Danville City, Dickenson, Dinwiddie, Emporia City, Essex, Fairfax, Fairfax City, Falls Church City, Fauquier, Floyd, Fluvanna, Franklin, Franklin City, Frederick, Fredericksburg City, Galax City, Giles, Gloucester, Goochland, Grayson, Greene, Greensville, Halifax, Hampton City, Hanover, Harrisonburg City, Henrico, Henry, Highland, Hopewell City, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Lee, Lexington City, Loudoun, Louisa, Lunenburg, Lynchburg City, Madison, Manassas City, Manassas Park City, Martinsville City, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Newport News City, Norfolk City, Northampton, Northumberland, Norton City, Nottoway,

Orange, Page, Patrick, Petersburg City, Pittsylvania, Poquoson City, Portsmouth City, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Radford City, Rappahannock, Richmond, Richmond City, Roanoke, Roanoke City, Rockbridge, Russell, Salem City, Scott, Shenandoah, Smyth, Southampton, Spotsylvania, Stafford, Staunton City, Suffolk City, Surry, Sussex, Tazewell, Virginia Beach City, Warren, Washington, Waynesboro City, Westmoreland, Williamsburg City, Winchester City, Wise, Wythe, York.

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Service at 1-844-368-7151 (TTY users call 711) to see if we have a plan in your new area.

When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

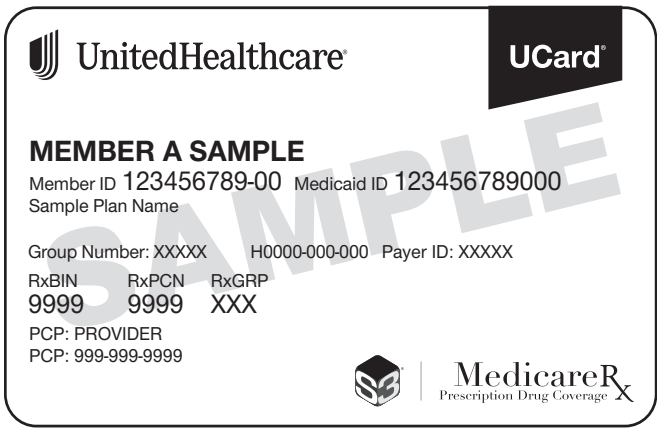
Section 2.4 U.S. Citizen or Lawful Presence

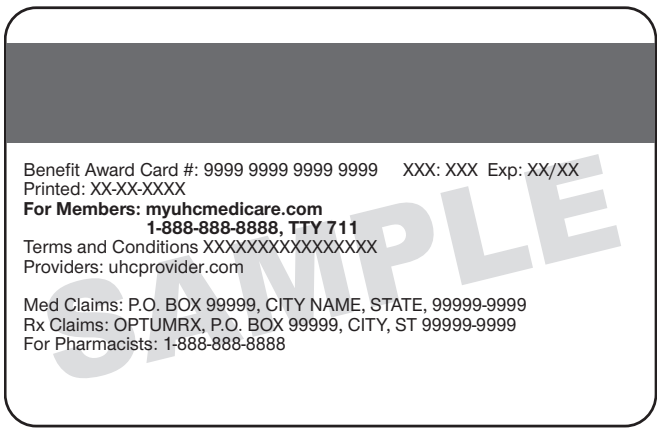
You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify UHC Dual Complete VA-Y001 (HMO-POS D-SNP) if you're not eligible to stay a member of our plan on this basis. UHC Dual Complete VA-Y001 (HMO-POS D-SNP) must disenroll you if you do not meet this requirement.

Section 3 Important membership materials

Section 3.1 Your UnitedHealthcare UCard

Use your UnitedHealthcare UCard® whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. This will help your provider bill correctly. Sample UnitedHealthcare UCard®:





DON'T use your red, white and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your UnitedHealthcare UCard, you

may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If your UnitedHealthcare UCard is damaged, lost, or stolen, call Customer Service at 1-844-368-7151 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The **Provider Directory**, available at myUHC.com/CommunityPlan, lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full.

You must use network providers to get your medical care and services, except for covered routine dental services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it's unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases when UHC Dual Complete VA-Y001 (HMO-POS D-SNP) authorizes use of out-of-network providers.

Members of this plan may use their Point of Service (POS) benefits to see non-network providers for covered routine dental services only. Go to Chapter 3 for more specific information about POS.

Get the most recent list of providers and suppliers on our website at myUHC.com/CommunityPlan.

If you don't have a **Provider Directory**, you can ask for a copy (electronically or in paper form) from Customer Service at 1-844-368-7151 (TTY users call 711). Requested paper Provider Directories will be mailed to you within 3 business days.

Section 3.3 Pharmacy Directory

The Pharmacy Directory at myUHC.com/CommunityPlan lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the Pharmacy Directory to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in the plan's network.

If you don't have a **Pharmacy Directory,** you can ask for a copy from Customer Service at 1-844-368-7151 (TTY users call 711). You can also find this information on our website at myUHC.com/CommunityPlan.

Section 3.4 Drug List (Formulary)

Our plan has a **List of Covered Drugs** (also called the Drug List or Formulary). It tells which prescription drugs are covered under the Part D benefit included in UHC Dual Complete VA-Y001 (HMO-POS D-SNP). 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 6. Medicare approved the UHC Dual Complete VA-Y001 (HMO-POS D-SNP) Drug List.

In addition to the drugs covered by Part D, some prescription drugs are covered for you under your Medicaid benefits. You can learn more about prescription drug coverage under your Cardinal Care by contacting your Cardinal Care health plan or Virginia Department of Medical Assistance Services (Medicaid) listed in Chapter 2 of this booklet. Your Cardinal Care health plan or Virginia Department of Medical Assistance Services (Medicaid) may also be able to provide a Medicaid Drug List that tells you how to find out which drugs are covered under Medicaid. Cardinal Care is the name of your Medicaid Health Plan.

The Drug List also tells if there are any rules that restrict coverage for a drug.

To get the most complete and current information about which drugs are covered, visit myUHC.com/CommunityPlan or call Customer Service at 1-844-368-7151 (TTY users call 711).

Section 4 Summary of important costs

	Your costs in 2026
Monthly plan premium* (You must also continue to pay your Medicare Part B premium unless it is paid for you by Cardinal Care Medicaid.) * Your premium can be higher than this amount. Go to Section 4.1 for details.	$0
Maximum out-of-pocket amounts This is the **most** you will pay out-of-pocket for your covered Part A and Part B services. (Go to Chapter 4 Section 1.2 for details.)	From network providers: $0 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Primary care office visits	$0 copayment per visit.
Specialist office visits	$0 copayment per visit.
Inpatient hospital stays	$0 copayment for each Medicare-covered hospital stay for unlimited days.

	Your costs in 2026
Part D drug coverage deductible (Go to Chapter 6, Section 4 for details.)	Because we have no deductible, this payment stage does not apply to you.
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**For all covered drugs:** $0 copayment[1] **Catastrophic Coverage Stage:** During this payment stage, you pay nothing for your covered Part D drugs.

[1] You pay a maximum of $0 for each 1-month supply of Part D covered insulin drugs until you reach the Catastrophic Coverage stage where you pay $0.

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium unless you qualify for “Extra Help” with your prescription drug costs. You will not pay a monthly Plan premium (prescription drug plan premium) if you qualify for “Extra Help”. People with Medicare and Medicaid automatically qualify for “Extra Help”. Because you qualify for “Extra Help”, for 2026 the monthly premium for our plan is $0.

In some situations, your plan premium could be less

The “Extra Help” program helps people with limited resources pay for their drugs. Learn more about this program in Chapter 2, Section 7. If you qualify, enrolling in the program might lower your monthly plan premium.

If you **already** get help from this program, **the information about premiums in this Evidence of Coverage may not apply to you**.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the Medicare & You 2026 handbook in the section called “2026 Medicare Costs.” Download a copy from the Medicare website at

(medicare.gov/medicare-and-you) or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

As a member of UHC Dual Complete VA-Y001 (HMO-POS D-SNP) you receive up to a $0.40 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.

In addition to paying the monthly plan premium, some members are required to pay other Medicare premiums. As explained in Section 2 above, in order 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 VA-Y001 (HMO-POS D-SNP) members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of the plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Because you are dually-eligible, the LEP doesn't apply to you as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. "Creditable drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in UHC Dual Complete VA-Y001 (HMO-POS D-SNP), we let you know the amount of the penalty.

You don't have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs
- You went less than 63 days in a row without creditable coverage
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get

this information in a letter or in a newsletter from our plan. Keep this information because you may need it if you join a Medicare drug plan later.

- **Note:** Any letter or notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard drug plan pays
- **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage

Medicare determines the amount of the Part D late enrollment penalty. Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is $38.99.
- To calculate your monthly penalty, you multiply the penalty percentage by the national base beneficiary premium and round it to the nearest 10 cents. In the example here it would be 14% times $38.99, which equals $5.46. This rounds to $5.50. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty.**

Three important things to note about the monthly Part D late enrollment penalty:

- **The penalty may change each year** because the national base beneficiary premium can change each year
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're <u>under</u> 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

Section 4.4 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 www.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).

Section 5 More information about your monthly plan premium

Section 5.1 How to pay our plan premium

There are four ways you can pay our plan premium.

Option 1: Pay by check

We will send you a monthly bill for our monthly plan premium. Make your payment payable to UnitedHealthcare. Please see your bill for the mailing address and other information. Include your member ID number on your check or money order. If making a payment for more than one member, include a payment slip for each member. Include the member ID number for each member on the check or money order. All payments must be received on or before the due date shown on the monthly bill. If you need your monthly bill replaced, please call Customer Service at 1-844-368-7151 (TTY users call 711).

Option 2: Electronic Funds Transfer

Instead of paying by check, you can have our monthly plan premium automatically deducted from your checking account. Your monthly payment will be deducted around the 5th of each month. If you wish to sign up for Electronic Funds Transfer (EFT), you may follow the instructions on your monthly bill, or you may call Customer Service at 1-844-368-7151 (TTY users call 711).

Option 3: Paying by credit card

Instead of paying by check, you can pay our monthly plan premium with your credit card. If you wish to sign up to use your credit card to pay our monthly plan premium please call Customer Service at 1-844-368-7151 (TTY users call 711).

Option 4: Have plan premium deducted from your monthly Social Security check

Changing the way you pay our premium

If you decide to change how you pay your premium, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure your plan premium is paid on time. Please contact Customer Service at 1-844-368-7151 (TTY users call 711) to notify us of your premium payment option choice or if you'd like to change your existing option.

If you have trouble paying your plan premium

Our plan premium is due in our office by the first day of the month. If we don't get your payment by the first day of the month, we'll send you a notice. In addition, we have the right to pursue collection of these premium amounts you owe.

If you are having trouble paying your premium on time, please contact Customer Service at 1-844-368-7151 (TTY users call 711) to see if we can direct you to programs that will help with your costs.

If we end your membership because you didn't pay our plan premium, you will have health coverage under Original Medicare. As long as you're getting Extra Help with your prescription drug costs, you'll continue to have Part D drug coverage. Medicare will enroll you into a new prescription drug plan for your Part D coverage.

At the time we end your membership, you may still owe us for unpaid premiums. We have the right to pursue collection of the premiums you owe. If you request enrollment in one of our plans and have unpaid premiums in a current or prior plan of ours, we have the right to require payment of any premium amounts you owe, before allowing you to enroll.

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance that was out of your control and that made you unable to pay our plan premium you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 9 to learn how to make a complaint or you can call us at 1-844-368-7151 between 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept. TTY users should call 711. You must make your request no later than 60 calendar days after the date your membership ends.

Section 5.2 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

If you become eligible for Extra Help or lose your eligibility for Extra Help during the year, the part of our plan premium you have to pay may change. If you qualify for Extra Help with your drug coverage costs, Extra Help pays part of your monthly plan premiums. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover. If you lose your eligibility for Extra Help during the year, you'll need to start paying the full monthly plan premium. Find out more about Extra Help in Chapter 2, Section 7.

Section 6 Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider.

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.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number.
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid).
- Any liability claims, such as claims from an automobile accident.
- If you're admitted to a nursing home.
- If you get care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you participate in a clinical research study. (**Note:** You're not required to tell our plan about the clinical research studies you intend to participate in but we encourage you to do so.)

If any of this information changes, please let us know by calling Customer Service at 1-844-368-7151 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we'll send you a letter that lists any other medical or drug coverage that we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Service at 1-844-368-7151 (TTY users call 711). You may need to give your plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the "primary payer") pays up to the limits of its coverage. The insurance that pays second (the "secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.

- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare and/or employer group health plans have paid.

Chapter 2:
Phone numbers and resources

Section 1 UHC Dual Complete VA-Y001 (HMO-POS D-SNP) contacts

For help with claims, billing, or UCard questions, call or write to Customer Service. We'll be happy to help you.

Customer Service - Contact Information	
Call	1-844-368-7151 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept Customer Service 1-844-368-7151 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.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

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information	
Call	1-844-368-7151 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept

Coverage Decisions for Medical Care – Contact Information	
Fax	1-888-950-1169
Write	UnitedHealthcare Customer Service Department (Organization Determinations) P.O. Box 30769, Salt Lake City, UT 84130-0769
Website	myUHC.com/CommunityPlan

Appeals for Medical Care – Contact Information	
Call	**1-844-368-7151** Calls to this number are free. Hours of Operation: 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
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	For fast/expedited appeals only: **1-866-373-1081**
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6103, MS CA120-0360, Cypress, CA 90630-0023
Website	**myUHC.com/CommunityPlan**

Coverage Decisions for Part D Prescription Drugs – Contact Information	
Call	1-844-368-7151 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Write	Optum Rx Prior Authorization Department

Coverage Decisions for Part D Prescription Drugs – Contact Information	
	P.O. Box 25183, Santa Ana, CA 92799
Website	myUHC.com/CommunityPlan

Appeals for Part D Prescription Drugs – Contact Information	
Call	1-844-368-7151 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept For fast/expedited appeals for Part D prescription drugs: 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
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	For standard Part D prescription drug appeals: 1-877-960-8235 For fast/expedited Part D prescription drug appeals: 1-866-308-6296
Write	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6103, MS CA120-0368, Cypress, CA 90630-0023
Website	myUHC.com/CommunityPlan

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care – Contact Information	
Call	**1-844-368-7151** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept For fast/expedited complaints about 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

Complaints about Medical Care – Contact Information	
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	For fast/expedited complaints only: **1-866-373-1081**
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6103, MS CA120-0360, Cypress, CA 90630-0023
Medicare website	To submit a complaint about UHC Dual Complete VA-Y001 (HMO-POS D-SNP) directly to Medicare, go to Medicare.gov/my/medicare-complaint.

Complaints about Part D Prescription Drugs – Contact Information	
Call	**1-844-368-7151** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept For fast/expedited complaints about Part D prescription drugs: **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
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	For standard Part D prescription drug complaints: **1-877-960-8235** For fast/expedited Part D prescription drug complaints: **1-866-308-6296**
Write	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6103, MS CA120-0368, Cypress, CA 90630-0023
Medicare website	To submit a complaint about UHC Dual Complete VA-Y001 (HMO-POS D-SNP) directly to Medicare, go to Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests – Contact Information	
Call	**1-844-368-7151** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Write	Medical claims payment requests: UnitedHealthcare P.O. Box 5220, Kingston, NY 12402-5220 Part D prescription drug payment requests: Optum Rx P.O. Box 650287, Dallas, TX 75265-0287
Website	**myUHC.com/CommunityPlan**

Section 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, 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 (CMS). This agency contracts with Medicare Advantage organizations, including our plan.

Medicare – Contact Information	
Call	**1-800-MEDICARE, (1-800-633-4227)** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.

Medicare – Contact Information	
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 preventive 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. You can also visit Medicare.gov to tell Medicare about any complaints you have about UHC Dual Complete VA-Y001 (HMO-POS D-SNP). **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.

Section 3 State Health Insurance Assistance Program (SHIP)

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 your state, the SHIP is called Virginia Insurance Counseling and Assistance Program (VICAP).

Your 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.

SHIP counselors can help you understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems, and help you understand your Medicare plan choices, and answer questions about switching plans.

State Health Insurance Assistance Program (SHIP) – Contact Information
Virginia
Virginia Insurance Counseling and Assistance Program (VICAP)

Call	**1-800-552-3402**
TTY	**711**
Write	1610 Forest AVE, STE 100, Henrico, VA 23229
Website	**https://www.vda.virginia.gov/vicap.htm**

Section 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Virginia, the Quality Improvement Organization is called Commence Health BFCC-QIO Program.

Your state's Quality Improvement Organization has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. The state's Quality Improvement Organization is an independent organization. It's not connected with our plan.

Contact your state's Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

	Quality Improvement Organization (QIO) – Contact Information **Virginia** **Commence Health BFCC-QIO Program**
Call	1-888-396-4646 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	P.O. Box 2687, Virginia Beach, VA 23450
Website	https://www.commencehealthqio.cms.gov/

Section 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount, or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, contact Social Security to let them know.

	Social Security – Contact Information
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	SSA.gov

Section 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. As a member of this plan, you qualify for Medicare and Medicaid. Depending on your State and eligibility, Medicaid may pay for homemaker, personal care and other services that are not paid for by Medicare.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year.

You can enroll in this plan if you are in one of these Medicaid categories:

- **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance and copayment amounts for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).

- **Specified Low-Income Medicare Beneficiary (SLMB+):** Medicaid pays your Part B premium and provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from your state Medicaid agency in paying your Medicare cost share amounts. Generally your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost sharing when a service or benefit is not covered by Medicaid.

- **Full Benefits Dual Eligible (FBDE):** Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from the State Medicaid Office in paying your Medicare cost share amounts. Generally your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost sharing when a service or benefit is not covered by Medicaid.

If you have questions about the help you get from Medicaid, contact Virginia Department of Medical Assistance Services (Medicaid).

	State Medicaid Program – Contact Information **Virginia** **Virginia Department of Medical Assistance Services (Medicaid)**
Call	**1-855-242-8282** **8 a.m. - 6 p.m. ET, Monday - Friday**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	600 E Broad ST, Richmond, VA 23219
Website	http://www.dmas.virginia.gov/

Method	**State Medicaid Office (for information about eligibility) – Contact Information** **Virginia** **Cover Virginia**
Call	1-833-522-5582 8 a.m. - 6 p.m. ET, Monday - Friday
TTY	1-888-221-1590

Method	State Medicaid Office (for information about eligibility) – Contact Information Virginia Cover Virginia
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	600 East Broad ST, Richmond, VA 23219
Website	https://coverva.dmas.virginia.gov/

Method	State Medicaid Office (for information about coverage and services) – Contact Information Virginia Cover Virginia
Call	1-855-242-8282 8 a.m. - 6 p.m. ET, Monday - Friday
TTY	1-888-221-1590 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	600 East Broad ST, Richmond, VA 23219
Website	https://coverva.dmas.virginia.gov/

The Ombudsman program helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

Method	State Ombudsman Program – Contact Information Virginia Virginia LTC Ombudsman Program - Department for Aging and Rehabilitative Services
Call	1-800-552-5019 8:15 a.m. - 5 p.m. local time, Monday - Friday
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Method	State Ombudsman Program – Contact Information Virginia Virginia LTC Ombudsman Program - Department for Aging and Rehabilitative Services
Write	8004 Franklin Farms DR, Henrico, VA 23229
Website	http://www.elderrightsva.org/

The long-term care ombudsman program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Method	State Long-Term Care Ombudsman Program Virginia Virginia LTC Ombudsman Program - Department for Aging and Rehabilitative Services
Call	1-800-552-5019 8:15 a.m. - 5 p.m. local time, Monday - Friday
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	8004 Franklin Farms DR, Henrico, VA 23229
Website	http://www.elderrightsva.org/

Section 7 Programs to help people pay for prescription drugs

The Medicare website (Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and get Extra Help from Medicare to pay for your prescription drug plan costs. You don't need to do anything further to get this Extra Help.

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users call 1-800-325-0778; or
- Your State Medicaid Office 1-855-242-8282.

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right 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 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 the payment directly to the state. Call Customer Service 1-844-368-7151 (TTY users call 711) if you have questions.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the State.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call the state ADAP office listed below.

	AIDS Drug Assistance Program (ADAP) – Contact Information Virginia Medication Assistance Program (MAP)
Call	1-800-533-4148 8 a.m.-5 p.m. local time, Monday-Friday
Website	https://www.vdh.virginia.gov/disease-prevention/vamap/

Section 8 Railroad Retirement Board (RRB)

The Railroad Retirement Board 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 Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

	Railroad Retirement Board (RRB) – Contact Information
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday.

	Railroad Retirement Board (RRB) – Contact Information
	Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number aren’t free.
Website	RRB.gov

Section 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Service at 1-844-368-7151 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan or enrollment periods to make a change. TTY users call 1-877-486-2048.

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**. The benefits administrator can help you understand how your current drug coverage will work with our plan.

Chapter 3:
Using our plan for your medical services

Section 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for covered services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare and Medicaid health plan, UHC Dual Complete VA-Y001 (HMO-POS D-SNP) must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare as noted in Chapter 4.

The plan will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** "Medically necessary" means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
  - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.

- You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.

- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. **Here are 3 exceptions:**
  - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost-sharing you normally pay in-network. In this situation, we will cover these services as if you got the care from a network provider. You must get approval from us before you start receiving care from an out-of-network provider. Please contact Customer Service, or have your PCP or the out-of-network provider call us to get approval (phone numbers are printed on the cover of this booklet).
  - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider that's outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

While you are a member of our Point of Service (POS) plan you may use either network providers or out-of-network providers for covered routine dental services. Please see Ch. 3, Sec. 2.3.

Section 2 Use network and out-of-network providers to get medical care

Section 2.1 You must choose a primary care provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP 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.

How to choose a PCP

You must select a PCP from the **Provider Directory** at the time of your enrollment.

Because your access to network specialists and hospitals is based upon your PCP selection, if there are specific hospitals or physicians or other providers that you want to use, be sure to find out if a PCP refers to those providers, as part of your selection process.

For a copy of the most recent **Provider Directory**, or for help in selecting a PCP, call Customer Service or visit the website listed in Chapter 2 of this booklet 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 may change your PCP at any time. See “Changing your PCP” below.

How to change your PCP

You can change your PCP for any reason, at any time. It’s also possible that your PCP might leave our plan’s network of providers and you’d need to choose a new PCP.

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

Section 2.2 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP.

- Routine women’s health care, including breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you’re either temporarily outside our plan’s the 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 plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you’re temporarily outside our plan’s service area. If possible, call Customer Service at 1-844-368-7151

(TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

- 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.
- For all other services, please refer to the Chapter 4 Medical Benefits Chart to determine if a referral is required in advance from your PCP.

Section 2.3 How to get care from specialists and other network providers

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

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

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 2.1 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.

When a specialist or another network provider leaves our plan

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose 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 3 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 3 months.

- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

You may call Customer Service for assistance at the number listed in Chapter 2 of this booklet.

Some services require prior authorization from the plan in order to be covered. Obtaining prior authorization is the responsibility of the PCP or treating provider. Services and items requiring prior authorization are listed in Medical Benefits Chart in Chapter 4, Section 2.

Section 2.4 How to get care from 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**. Otherwise, care that you get from out-of-network providers will not be covered unless the care meets one of the three exceptions described in Section 1.2 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 3 in this chapter.

Section 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need to get approval or a referral first from your PCP. You **don't** need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the world.

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.

The doctors giving you emergency care will decide when your condition is stable and when the medical emergency is over.

When you receive emergency care in the United States, after the emergency is over you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.
When you receive emergency care outside of the United States under the worldwide emergency benefit, only the medical services directly related to the immediate medical emergency are covered while you remain in a foreign country. Follow-up care received outside of the United States after your condition has been stabilized is generally not covered, even if the care is related to the original emergency. Coverage is limited to emergency services required to stabilize your condition. Any care received beyond stabilization must occur within the United States to be eligible for coverage.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor has said that it **wasn't** an emergency, we will cover additional care **only** if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care, or
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service 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. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed services even if you're outside our plan's service area or our plan network is temporarily unavailable.

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider. Check your **Provider Directory** for a list of network Urgent Care Centers.

Our plan covers worldwide emergency and urgently needed services outside the United States under the following circumstances: emergency services, including emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility 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. 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.

Section 3.3 Get 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 the following website: **uhc.com/disaster-relief-info** or contact Customer Service for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost-sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

Section 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan

Our plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization, you're responsible for paying the full cost of services. However, before paying for the cost of the service, contact your state Medicaid office to find out if the service is covered by Medicaid.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. For example, if your plan covers one routine physical exam per year and you receive that routine physical but choose to have a second

routine physical within the same year, you pay the full cost of the second routine physical. Any amounts that you pay after you have reached the benefit limitation do not count toward your annual out-of-pocket maximum. (See Chapter 4 for more information on your plan's out-of-pocket maximum.)

Section 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate 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 participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you get as part of the study. If you tell us that you are in a qualified clinical trial, you're only responsible for in-network cost-sharing for the services in that trial. If you paid more - for example, if you already paid the Original Medicare cost-sharing amount – we'll reimburse the difference between what you paid and the in-network cost-sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you **don't** need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study **don't** need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- 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 if it's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare **won't** pay for the new item or service the study is testing unless Medicare would cover the item or service even if you **weren't** in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free of charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication Medicare and Clinical Research Studies, available at Medicare.gov/coverage/clinical-research-studies. You can also call 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048.

Section 6 Rules for getting care in a "religious non-medical health care institution"

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get 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 conscientiously opposed to getting medical treatment that is non-excepted.

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers **non-religious** aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - **– and –** you must get approval in advance from our plan 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.

Section 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of our plan, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan**. You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Customer Service at 1-844-368-7151 (TTY users call 711) for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage our plan will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months you rent the equipment. For the remaining 24 months the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

Chapter 4:
Medical Benefits Chart (what's covered and what you pay)

Section 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of UHC Dual Complete VA-Y001 (HMO-POS D-SNP). This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include.

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

QMB members - you do not have any costs for Medicare-covered services, except your prescription copayments if you are enrolled in Medicare as a Qualified Medicare Beneficiary (QMB) and Medicaid. Your coinsurance, deductibles and copayments (except for Part D prescription drugs) are paid by Medicaid.

Show your UCard when getting health care services. It will help your health care providers coordinate payment.

Call Customer Service at the telephone number listed in Chapter 2 of this booklet if:

- you are asked to pay for covered services,
- your provider will not see you or
- you have other questions

If you receive notice that your Medicaid coverage has expired, please call your Medicaid office right away to reapply for assistance. Your Medicaid Agency phone number is listed in Chapter 2 of this booklet. Please call Customer Service at the number listed in Chapter 2 of this booklet if you have questions.

Grace Period

Members who are (Qualified Medicare Beneficiaries) QMB or have full Medicaid benefits - if you lose your Medicaid eligibility, you can remain enrolled in this Medicare plan for up to 6 months. You

must re-enroll in Medicaid before the end of the 6 month period to keep your Medicare benefits with this plan. If you go to your provider during the 6 month period, you will have out-of-pocket costs that your Medicare plan will not cover. You will be responsible for those costs until you regain your Medicaid eligibility. Your out-of-pocket costs may include Medicare plan deductibles, copayments and coinsurance up to the Original Medicare amounts, which can be found at medicare.gov. For in-network Medicare-covered services, you will be responsible for up to $9,250 of cost sharing calculated at the Original Medicare amounts. Out-of-network services do not count toward this maximum. In addition, if you lose your Part D Extra Help eligibility, you will also need to pay the plan premium. Please call Customer Service (phone numbers are printed on the cover of this booklet) for additional information related to out-of-pocket costs during the grace period.

If you do not re-enroll in Medicaid during the 6 month period, you will be disenrolled from our plan. You will be enrolled in Original Medicare. To re-enroll for Medicaid, contact the Virginia Department of Medical Assistance Services (Medicaid) office.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Note: Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. You're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Medicare Advantage Plans have limits on the amount you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket amount for medical services**. For calendar year 2026 the MOOP amount is $0**.

The amounts you pay for your deductibles, copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for our plan premium and for your Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $0, you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services UHC Dual Complete VA-Y001 (HMO-POS D-SNP) covers and what you pay out-of-pocket for each service (Part D drug coverage is covered in Chapter 5) . The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) **must** be medically necessary. "Medically necessary" means that the services, supplies, or drugs are

needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's emergency or urgent care or unless our plan or a network provider gave you a referral. This means that you pay the provider in full for out-of-network services you get.
- You have a Primary care provider (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.
- Some services listed in the Medical Benefits Chart are covered **only** if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). There are also some services that require you to obtain approval by working directly with your assigned Care Team.
  - Covered services that may need approval in advance are marked by a double dagger (††) in the Medical Benefits Chart.
  - Network providers agree by contract to obtain prior authorization from the plan.
  - If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- You're covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost-sharing for Medicare services. Medicaid also covers services Medicare doesn't cover, like long-term care and home and community-based services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your **Medicare & You 2026** handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.
- If you're within our plan's 6-month period of deemed continued eligibility, we'll continue to provide all appropriate Medicare Advantage plan Medicare-covered benefits. However, during this period, we won't continue to cover Medicaid benefits that are included under the Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would

otherwise be liable.

- You don't pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.
  - 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.

This apple shows preventive services in the Medical Benefits Chart.

Medically Necessary - means health care services, supplies, or drugs needed for the prevention, diagnosis, or treatment of your sickness, injury or illness that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with **Generally accepted standards of medical practice**.
- Most appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, or illness.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Meet, but do not exceed your medical need, are at least as beneficial as an existing and available medically appropriate alternative, and are furnished in the most cost-effective manner that may be provided safely and effectively.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

Medical Benefits Chart

Covered service	What you pay
Abdominal aortic aneurysm screening A one-time (once per lifetime) screening ultrasound for people at risk. The 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 for chronic low back pain Covered services include: Up to 12 visits in 90 days performed by, or under the supervision of a physician (or other medical provider as described below) are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: □Lasting 12 weeks or longer; □nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); □not associated with surgery; and □not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **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 master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,	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 if you receive services from a primary care physician or specialist.[††] *Referral may be required.*

Covered service	What you pay
☐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 as required by Medicare. 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.	
Ambulance services Medicare-covered ambulance services within the United States, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. 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	$0 copayment for each one-way Medicare-covered ground trip. $0 copayment for each one-way Medicare-covered air trip. Non-emergency ambulance services are not covered out-of-network. *Your provider may need to obtain prior authorization for non-emergency transportation.*

Covered service	What you pay
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.	
Annual routine physical exam Includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. Annual Routine Physical Exam visits do not need to be scheduled 12 months apart but are limited to one visit each calendar year.	$0 copayment for a routine physical exam each year.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered 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 preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

Covered service	What you pay
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: One baseline mammogram between the ages of 35 and 39 One screening mammogram every 12 months for women age 40 and older Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copayment for each Medicare-covered cardiac rehabilitative visit.[††]
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the cardiovascular disease preventive benefit.

Covered service	What you pay
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) covered once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.
Cervical and vaginal cancer screening Covered services include: For all women: Pap tests and pelvic exams are covered once every 24 months If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: 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.
Chiropractic services Covered services include: Manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position). Manual manipulation is a treatment that uses hands-on pressure to gently move your joints and tissues. Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation, including: Maintenance therapy. Chiropractic treatment is considered maintenance therapy when continuous ongoing care is no longer expected to provide clinical improvements and the treatment becomes supportive instead of corrective.	$0 copayment for each Medicare-covered visit.[††]

Covered service	What you pay
☐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).	
Chronic care management services, including chronic pain management and treatment plan services If you have serious chronic conditions and receive chronic care management services, your provider develops a monthly comprehensive care plan that lists your health problems and goals, providers, medications, community services you have and need, and other information about your health. Your provider also helps coordinate your care when you go from one health care setting to another.	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.[††] *Referral may be required*. 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

Covered service	What you pay
	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).[††] *Referral may be required*.
Colorectal cancer screening The following screening tests are covered: • 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 are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 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 colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. 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
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. 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.[††]
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that 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	$0 copayment for Medicare-covered dental services.[††]

Covered service	What you pay
cancer involving the jaw, or oral exams prior to organ transplantation.	
Routine dental benefits You can get more information about this benefit 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.*††
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every plan year following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: Supplies to monitor your blood glucose: continuous glucose monitors (CGMs), blood glucose monitors	$0 copayment for each Medicare-covered continuous

Covered service	What you pay
(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-continuous-glucose-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. If you (or your provider) don't agree with the plan's coverage decision, you or your provider can file an appeal. You can also file an appeal if you don't agree with your provider's decision about the appropriate product or brand for your condition. (For more information about appeals, see Chapter 9.)	glucose monitor (CGM) and supplies with an approved prior authorization. There are no brand limitations for CGMs.[††] $0 copayment for each Medicare-covered blood glucose monitor (BGM).[††] For BGMs, we only cover Contour® and Accu-Chek® brands. Other BGM brands are not covered by our plan. Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide. Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus. For cost-sharing applicable to insulin and syringes, see Chapter 6.

Covered service	What you pay
☐For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	$0 copayment for each pair of Medicare-covered therapeutic shoes.[††]
☐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.
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," go to Chapter 12 and Chapter 3) Covered items include, but aren't limited to: 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, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at myUHC.com/CommunityPlan.	$0 copayment for Medicare-covered benefits.[††] Your cost sharing for Medicare oxygen equipment coverage is $0 copayment, every time you get covered equipment or supplies.[††] Your cost sharing won't change after you're enrolled for 36 months. If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in our plan, your cost sharing in our plan is $0 copayment.[††]
Emergency care Emergency care refers to services that are: ☐Furnished by a provider qualified to furnish emergency services, and	Within the United States: $0 copayment for each emergency room visit.

Covered service	What you pay
☐Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Within the United States, cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.	You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you are admitted to a hospital, you will pay cost-sharing as described in the "Inpatient hospital care" section in this benefit chart. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital.
Worldwide emergency coverage for emergency department services outside of the United States: ☐This includes emergency or urgently needed care and emergency ambulance transportation only 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	Outside the United States: $0 copayment for worldwide coverage for emergency services outside of the United States. In most cases you will pre-pay the foreign provider for the service and request reimbursement. Please see Chapter 7 Section 1.1 for expense reimbursement for worldwide emergency services.

Covered service	What you pay
covered outside of the United States, even if those services are related to a previous emergency. □Services provided by a dentist are not covered. □Provider access fees, appointment fees and administrative fees are not covered. □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.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	$0 copayment for each Medicare-covered exam.[††]
Hearing services - routine hearing exam We cover 1 hearing exam every year.	$0 copayment

Covered service	What you pay
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. Hearing aids purchased outside of UnitedHealthcare Hearing are not covered.	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 hearing aids are available nationwide through UnitedHealthcare Hearing (select products only). Hearing aids purchased outside of UnitedHealthcare Hearing are not covered.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: One screening exam every 12 months If you are pregnant, we cover: Up to 3 screening exams during a pregnancy	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency.	$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met.[††]

Covered service	What you pay
You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: □Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) □Physical therapy, occupational therapy, and speech therapy □Medical and social services □Medical equipment and supplies	Other copayments or coinsurance may apply (Please see Durable medical equipment and related supplies for applicable copayments or coinsurance).
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: □Professional services, including nursing services, furnished in accordance with our plan of care □Patient training and education not otherwise covered under the durable medical equipment benefit □Remote monitoring □Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	You will pay the cost-sharing that applies to primary care services, specialist physician services, or home health (as described under "Physician/ practitioner services, including doctor's office visits" or "Home health agency care") depending on where you received administration or monitoring services.[††] *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. [††] See "Medicare Part B prescription drugs" later in this

Covered service	What you pay
	chart for any applicable cost-sharing for drugs related to home infusion therapy.[††] See Chapter 6 for any applicable cost-sharing for Part D drugs related to home infusion therapy.
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our 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 for symptom control and pain relief □Short-term respite care □Home care When you're admitted to a hospice you have the right to stay in your plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.	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 VA-Y001 (HMO-POS D-SNP).

Covered service	What you pay
For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to obtain prior authorization): ☐If you get the covered services from a network provider and follow plan rules for getting service, you only pay our plan cost-sharing amount for in-network services ☐If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services covered by UHC Dual Complete VA-Y001 (HMO-POS D-SNP) but not covered by Medicare Part A or B:** UHC Dual Complete VA-Y001 (HMO-POS D-SNP) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition you pay cost-sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.	
Immunizations Covered Medicare Part B services include:	There is no coinsurance, copayment, or deductible for

Covered service	What you pay
☐Pneumonia vaccines ☐Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) 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 also cover most other adult vaccines under our Part D drug benefit, such as shingles or RSV vaccines. Go to Chapter 6 for more information.	the pneumonia, flu, Hepatitis B, or COVID-19 vaccines. There is no coinsurance, copayment, or deductible for all other Medicare-covered immunizations.
In-home support services Members with disabilities or other qualified medical conditions may be eligible for 28 hours of in-home support every month. Attendants can help with housekeeping, personal care, general supervision and more.	$0 copayment
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. Covered services include, but aren't limited to: ☐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)	$0 copayment for each Medicare-covered hospital stay for unlimited days each time you are admitted.[††] 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

Covered service	What you pay
☐Drugs and medications ☐Lab tests ☐X-rays and other radiology services ☐Necessary surgical and medical supplies ☐Use of appliances, such as wheelchairs ☐Operating and recovery room costs ☐Physical, occupational, and speech language therapy ☐Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. 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 VA-Y001 (HMO-POS D-SNP) Customer Service at 1-844-368-7151 TTY 711. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If UHC Dual Complete VA-Y001 (HMO-POS D-SNP) provides transplant services at a location outside of the pattern of care for transplants in your community and you chose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. See Chapter 4, Section 4 "Services that aren't covered by our plan (exclusions)" for more details.	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
☐Blood - including storage and administration. Coverage starts with the first pint of blood that you need. ☐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." This is called an "outpatient observation" stay. 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 www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	Outpatient observation cost sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Inpatient services in a psychiatric hospital 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 use disorder services	$0 copayment up to 90 days per benefit period, plus an additional 60 lifetime reserve days.[††] 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 Chapter 12.) 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 you get in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:	When your stay is no longer covered, these services will be covered as described in the following sections:
☐Physician services	Please refer below to Physician/ practitioner services, including doctor's office visits.
☐Diagnostic tests (like lab tests)	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
☐X-ray, radium, and isotope therapy including technician materials and services	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
☐Surgical dressings ☐Splints, casts and other devices used to reduce fractures and dislocations	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
☐Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	Please refer below to prosthetic and orthotic devices and related supplies.
☐Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs,	Please refer below to prosthetic and orthotic devices and related supplies.

Covered service	What you pay
and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	
☐Physical therapy, speech language therapy, and occupational therapy	Please refer below to Outpatient rehabilitation services.
Meal benefit This benefit can be used immediately following a covered inpatient hospital or skilled nursing facility (SNF) stay. 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 Prior authorization is required. Home-delivered meals are available nationwide.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare diabetes prevention program (MDPP)	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Covered service	What you pay
MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	
Medicare Part B Drugs These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: □Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical 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 were authorized by our plan □The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment □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	$0 copayment for each Medicare-covered chemotherapy drug and the administration of that drug.[††] $0 copayment for each Medicare-covered Part B drug.[††] Additionally, for the administration of that drug, 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 received drug administration or infusion services.

Covered service	What you pay
D drug coverage covers immunosuppressive drugs if Part B doesn't cover them Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug Some Antigens (for allergy shots): Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of 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 End-Stage Renal Disease (ESRD) or you need this drug to treat anemia	

Covered service	What you pay
related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Parenteral and enteral nutrition (intravenous and tube feeding) Chemotherapy Drugs, and the administration of chemotherapy drugs We also cover some vaccines under our Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

Covered service	What you pay
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: - U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. - Dispensing and administration of MAT medications (if applicable) - Substance use counseling - Individual and group therapy - Toxicology testing - Intake activities - Periodic assessments	$0 copayment for Medicare-covered opioid treatment program services.[††]
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to:	
- X-rays	$0 copayment for each Medicare-covered standard X-ray service.[††]
- Radiation (radium and isotope) therapy including technician materials and supplies	$0 copayment for each Medicare-covered radiation therapy service.[††]

Covered service	What you pay
☐Surgical supplies, such as dressings ☐Splints, casts, and other devices used to reduce fractures and dislocations Note: There is no separate charge for medical supplies routinely used in the course of an office visit and included in the provider's charges for that visit (such as bandages, cotton swabs, and other routine supplies.) However, supplies for which an appropriate separate charge is made by providers (such as, chemical agents used in certain diagnostic procedures) are subject to cost-sharing as shown.	$0 copayment for each Medicare-covered medical supply.[††]
☐Laboratory tests	$0 copayment for Medicare-covered lab services.[††]
☐Blood - including storage and administration (this means processing and handling of blood). Coverage begins with the first pint of blood that you need. ☐In addition, for the administration of blood infusion, you will pay the cost-sharing as described under the following sections of this chart, depending on where you received infusion services: ☐ Physician/practitioner services, including doctor's office visits ☐ Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers	$0 copayment for Medicare-covered blood services.[††]

Covered service	What you pay
Other outpatient diagnostic tests - non-radiological diagnostic services	$0 copayment for Medicare-covered 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.
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 problem Other outpatient diagnostic tests - radiological diagnostic services, not including x-rays	$0 copayment for Medicare-covered radiological diagnostic services, not including X-rays.[††] 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).

Covered service	What you pay
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they 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 licensure 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 and pay the cost-sharing amounts for outpatient hospital services. 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 the hospital staff. Get more information in the Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to:	
☐Services in an emergency department	Please refer to Emergency Care.
☐Laboratory and diagnostic tests billed by the hospital	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.

Covered service	What you pay
Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	Please refer to Outpatient mental health care.
X-rays and other radiology services billed by the hospital	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
Medical supplies such as splints and casts	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
Certain screenings and preventive services	Please refer to the benefits preceded by the “apple” icon.
Certain drugs and biologicals you can’t give yourself (Note: Self-administered drugs in an outpatient hospital are not usually covered under your Part B prescription drug benefit. Under certain circumstances, they may be covered under your Part D prescription drug benefit. For more information on Part D payment requests, see Chapter 7 Section 2.)	Please refer to Medicare Part B prescription drugs.
Services performed at an outpatient clinic	Please refer to Physician/ practitioner services, including doctor’s office visits.
Outpatient surgery or observation	Please refer to Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.

Covered service	What you pay
Outpatient infusion therapy For the drug that is infused, you will pay the cost-sharing as described in “Medicare Part B prescription drugs” in this benefit chart. In addition, for the administration of infusion therapy drugs, 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 surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers” in this benefit chart) depending on where you received drug administration or infusion services.	Please refer to Medicare Part B prescription drugs and Physician/practitioner services, including doctor’s office visits or Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you’re an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” This is called an “outpatient observation” stay. If you aren’t sure if you’re an outpatient, ask the hospital staff.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$0 copayment for each Medicare-covered **individual** therapy session.[††] $0 copayment for each Medicare-covered **group** therapy session.[††]
Outpatient rehabilitation services	$0 copayment for each Medicare-covered physical

Covered service	What you pay
Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, physician offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	therapy and speech-language therapy visit.[††] *Referral is required*. $0 copayment for each Medicare-covered occupational therapy visit.[††] *Referral is required*.
Outpatient substance use disorder services Outpatient treatment and counseling for substance use disorder.	$0 copayment for each Medicare-covered **individual** therapy session.[††] $0 copayment for each Medicare-covered **group** therapy session.[††]
Outpatient surgery and other medical services provided 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 and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "Outpatient Observation" stay. If you are not sure if you are an outpatient, you should ask your doctor or the hospital staff. 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.	$0 copayment for Medicare-covered surgery or other services provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges.[††] $0 copayment for Medicare-covered surgery or other services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges.[††] Outpatient surgical services that can be delivered in an available ambulatory surgery center must

Covered service	What you pay
See “Colorectal cancer screening” earlier in this chart for screening and diagnostic colonoscopy benefit information.	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.[††]
Over-the-counter (OTC) credit With this benefit, you'll get a credit loaded to your UCard each month to buy covered OTC items. Unused credit expires at the end of each month. Covered items include brand name and generic OTC products like vitamins, pain relievers, bladder control pads and first aid products. The credit cannot be used to buy tobacco or alcohol.	Monthly credit is $407
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

Covered service	What you pay
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 and utilities - 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 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) 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	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
☐Conditions associated with cognitive impairment ☐Conditions with functional challenges and require similar services Covered items include: ☐Healthy foods like fruits, vegetables, meat, seafood, dairy products, water and more. ☐Eligible utility bills like electricity, home heat like natural gas, water and home internet. The service address must match an address we have on file for you. You can use your credit at thousands of participating stores or place an order online. Home shipping is free and there is a $35 minimum to place an order. Taxes may apply. Visit the UCard Hub to learn more about using your benefit, check your balance, find covered products, locate participating stores and more.	
Partial hospitalization services and Intensive outpatient services **Partial hospitalization** is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	$0 copayment each day for Medicare-covered benefits.[††]

Covered service	What you pay
Physician/practitioner services, including doctor's office visits Covered services include:	
☐Medically-necessary medical or surgical services you get in a physician's office.	$0 copayment for services from a primary care physician or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a primary care physician's office (as allowed by Medicare).
☐Medically-necessary medical or surgical services you get in a certified ambulatory surgical center or hospital outpatient department.	See "Outpatient surgery" earlier in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.
☐Consultation, diagnosis, and treatment by a specialist.	$0 copayment for services from a specialist or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a specialist's office (as allowed by Medicare).[††] *Referral is required*.
☐Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment.	$0 copayment for each Medicare-covered exam.[††]

Covered service	What you pay
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 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.	$0 copayment
Medicare-covered telehealth services including: Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based	$0 copayment for each Medicare-covered visit.[††] *Referral is required.*

Covered service	What you pay
renal dialysis center, renal dialysis facility, or the member's 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 their location. ☐ 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 getting these telehealth services. ☐Exceptions can be made to the above for certain circumstances. ☐ Telehealth services provided by rural health clinics and federally qualified health centers. ☐ Medicare-covered remote monitoring services. ☐ 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.	

Covered service	What you pay
Consultation your doctor has with other doctors by phone, internet, or electronic health record.	
Second opinion by another network provider prior to surgery.	You will pay the cost-sharing that applies to specialist services (as described under "Physician/practitioner services, including doctor's office visits" above).[††] *Referral is required*.
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).	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.[††] *Referral may be required*.
Medically-necessary services that are covered benefits and are furnished by a physician/non-physician health care professional in your home.	$0 copayment for nurse practitioner, physician's assistant or other non-physician health care professional services.[††] 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.[††] *Referral may be required*.

Covered service	What you pay
Podiatry services Covered services include: □Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). □Routine foot care for members with certain medical conditions affecting the lower limbs.	$0 copayment for each Medicare-covered visit in an office or home setting.[††] 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.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: □FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. □Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. □Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	There is no coinsurance, copayment, or deductible for the PrEP benefit.

Covered service	What you pay
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: Digital rectal exam 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.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that 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; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to Vision services later in this table for more detail.	$0 copayment for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies.[††]
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. 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.[††]
Screening and counseling to reduce alcohol misuse	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce

Covered service	What you pay
We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	alcohol misuse preventive benefit.
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.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Covered service	What you pay
For LDCT lung cancer screenings after the initial LDCT screening: the member must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place 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 STIs preventive benefit.
Services to treat kidney disease Covered services include: Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime.	$0 copayment for Medicare-covered benefits.

Covered service	What you pay
☐Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	$0 copayment for Medicare-covered benefits.††
☐Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for Medicare-covered benefits.
☐Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	These services will be covered as described in the following sections: Please refer to Inpatient hospital care.
☐Home dialysis equipment and supplies	Please refer to Durable medical equipment and related supplies.
☐Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	Please refer to Home health agency care.
Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.	
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) Covered services include but aren't limited to: ☐Semiprivate room (or a private room if medically necessary) ☐Meals, including special diets ☐Skilled nursing services	$0 copayment for each Medicare-covered SNF stay, up to 100 days.†† You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines.

Covered service	What you pay
☐Physical therapy, occupational therapy and speech therapy ☐Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) ☐Blood - including storage and administration. Coverage begins with the first pint of blood that you need. ☐Medical and surgical supplies ordinarily provided by SNFs ☐Laboratory tests ordinarily provided by SNFs ☐X-rays and other radiology services ordinarily provided by SNFs ☐Use of appliances such as wheelchairs ordinarily provided by SNFs ☐Physician/practitioner services A 3-day prior hospital stay is not required. Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. ☐A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). ☐A SNF where your spouse or domestic partner is living at the time you leave the hospital.	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 (counseling to stop smoking or tobacco use) 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 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and have a referral from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: - Consist of sessions lasting 30-60 minutes, comprising of a therapeutic exercise-training program for PAD in patients with claudication - Be conducted in a hospital outpatient setting or a physician's office - Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD - Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques	$0 copayment for each Medicare-covered supervised exercise therapy (SET) visit.[††]

Covered service	What you pay
SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Routine transportation Details of this benefit: Unlimited 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, gyms, grocery stores, or hearing and vision appointments. Each one-way trip must not exceed 50 miles of driving distance. Transportation services must be requested 2 business days prior to a routine scheduled appointment. One companion is allowed per trip (companion must be at least 18 years old). On some trips, you may have to share a ride with other transportation clients. Trips are curb-to-curb service. Wheelchair-accessible vans are available upon request. Drivers do not have medical training. In case of emergency, call 911. This benefit does not cover transportation by: Stretcher Ambulance 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 services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. 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 plan network is temporarily unavailable. 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 received outside of the United States. Please see Chapter 7 Section 1.1 for expense reimbursement for worldwide services.
Vision services Covered services include:	
☐Outpatient physician services provided by an ophthalmologist or optometrist for the diagnosis and treatment of diseases and injuries of the eye, including diagnosis or treatment for age-related macular degeneration or cataracts. ☐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 exam.[††]
☐For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk	$0 copayment for Medicare-covered glaucoma screening.

Covered service	What you pay
of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older.	
For people with diabetes or signs and symptoms of eye disease, eye exams to evaluate for eye disease are covered per Medicare guidelines. Annual examinations by an ophthalmologist or optometrist are recommended for asymptomatic diabetics. For people with diabetes, screening for diabetic retinopathy is covered once per year.	$0 copayment for Medicare-covered eye exams to evaluate for eye disease.[††]
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 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any upgrades are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating).	$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
Vision services - routine eyewear 1 pair of lenses/frames and contact lenses every year	Provided by: MARCH® Vision Care

Covered service	What you pay
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.	$0 copayment Plan pays up to $300 toward your purchase of lenses/frames and contact lenses.
"Welcome to Medicare" Preventive Visit Our plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. 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. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know 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 services that do not count toward your maximum out-of-pocket amount.

†† Covered services where your provider may need to request prior authorization.

Covered Routine Dental Benefits Included with Your Plan:
Annual Dental Maximum: $3,000

- 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), 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 1-844-368-7151 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 1-844-368-7151 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 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 1-844-368-7151 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 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.

Section 3 Services covered outside of UHC Dual Complete VA-Y001 (HMO-POS D-SNP)

Benefits covered outside of UHC Dual Complete VA-Y001 (HMO-POS D-SNP)
For services that aren't covered by UHC Dual Complete VA-Y001 (HMO-POS D-SNP) but are available through Medicaid please see your Medicaid Member Handbook. You can find your Medicaid Member Handbook online at **myUHC.com/CommunityPlan**. Or you can call Customer Service at the number listed in Chapter 2 of this booklet to have a paper copy sent to you.

Section 4 Services that aren't covered by our plan (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, aren't covered by this plan.

The chart below describes some services and items that aren't covered by Medicare under any conditions or are covered by Medicare only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself, except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them.

The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 9, Section 6.3.)

Services not covered by Medicare	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital	Covered only when medically necessary

Services not covered by Medicare	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
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 daily living, such as bathing or dressing.	Not covered under any condition
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation	Not covered under any condition
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Chiropractic services (Medicare-covered)	Manual manipulation of the spine to correct a subluxation is covered. Excluded from Medicare coverage is any service other than manual manipulation of the spine for the treatment of subluxation.
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care

Services not covered by Medicare	Covered only under specific conditions
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease. (As specifically described in the medical benefits chart in this chapter.)
Outpatient prescription drugs	Some coverage provided according to Medicare guidelines. (As specifically described in the medical benefits chart in this chapter or as outlined in Chapter 6.)
Elective hysterectomy, tubal ligation, or vasectomy, if the primary indication for these procedures is sterilization. Reversal of sterilization procedures, penile vacuum erection devices, or non-prescription contraceptive supplies.	Not covered under any condition
Acupuncture (Medicare-covered)	Available for people with chronic low back pain under certain circumstances. (As specifically described in the medical benefits chart in this chapter.)
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Physical exams that are for employment, licenses, insurance, court hearings, travel, dietary counseling, weight loss programs, premarital purposes, pre-adoption purposes or other non-preventive reasons	Not covered under any condition
Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services	Services are only covered when the ambulance pick-up address is located in rural New York and applicable conditions are met. Members are responsible for all paramedic intercept service costs that occur outside of rural New York.

Services not covered by Medicare	Covered only under specific conditions
unit, which do not provide ambulance transport)	
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	Not covered under any condition
Immunizations for foreign travel purposes	Not covered under any condition
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	Not covered under any condition
Equipment or supplies that condition the air, heating pads, hot water bottles, wigs and their care, and other primarily non-medical equipment.	Disposable or non-reusable items such as incontinence supplies are not covered under Medicare but may be covered under the OTC benefit.
Any non-emergency care received outside of the United States and the U.S. Territories.	Not covered under any condition. 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. Dental care is not covered outside of the United States under any condition. Prescription or non-prescription drugs obtained outside of the United States are not covered under any condition.
Emergency or urgently needed care received outside of the	Covered only if paid directly by you and submitted to us for reimbursement, or when reimbursement is requested

Services not covered by Medicare	Covered only under specific conditions
United States and the U.S. Territories.	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. Administrative fees to cover the cost of billing are not reimbursable. Dental services are not covered under any condition. Prescription or non-prescription drugs obtained outside of the United States are not covered under any condition.
Travel or transportation expenses, including but not limited to air or land ambulance services, from a foreign country to the United States.	Not covered under any condition
Transplant related travel and 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	Eligible travel and lodging expenses when you are receiving covered transplant services at a location that is in the plan's transplant network for the type of transplant you need but that is outside the normal community pattern of care from your home include: **Transportation:** Vehicle mileage, economy/ coach airfare, taxi fares, or rideshare services. Eligible transportation services are not subject to a daily limit amount. **Lodging:** Costs for lodging or places to stay such as hotels, motels or short-term housing. You can be reimbursed for eligible lodging costs up to $125 per day total. Because Medicare-approved transplant centers are not available for every type of transplant in every state, your local community pattern of care for transplants may require that you travel some distance in order to receive your transplant. Travel and lodging expenses are not reimbursable if you receive a 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.

Services not covered by Medicare	Covered only under specific conditions
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.	Submission of the transplant travel reimbursement form must occur within 365 days of the date the travel or lodging expense was incurred.

Services not covered by Medicare	Covered only under specific conditions
Transplant-related travel and lodging costs are not covered for transplant donors.	
Self-administered drugs in an outpatient hospital	Covered only under specific conditions

We regularly review new procedures, devices and drugs to determine whether or not they are safe and effective for members. New procedures and technology that are safe and effective 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 safe and effective use 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.

Chapter 5:

Using plan coverage for Part D drugs

?

How can you get information about your drug costs?

Because you're eligible for Virginia Department of Medical Assistance Services (Medicaid), you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you're in the Extra Help program, some **information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you.**

Section 1 Basic rules for the plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. Our Drug List tells you how to find out about your Medicaid drug coverage.

The plan will generally cover your drugs as long as you follow these rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists
- You generally must use a network pharmacy to fill your prescription (Go to Section 2 **or you can fill your prescription through the plan's mail-order service**)
- Your drug must be on the plan's Drug List (go to Section 3)
- Your drug must be used for a "medically accepted indication". A medically accepted indication is a use of the drug that's either approved by the Food and Drug Administration (FDA) or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from the plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

Section 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

In most cases, your prescriptions are covered **only** if they're filled at the plan's network pharmacies. (Go to Section 2.5 for information about when we cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered drugs. The term “covered drugs” means all the Part D drugs that are on the plan’s Drug List.

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your **Pharmacy Directory**, visit our website (myUHC.com/CommunityPlan), and/or call Customer Service at 1-844-368-7151 (TTY users call 711).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves the plan’s network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, call Customer Service at 1-844-368-7151 (TTY users call 711) or use the **Pharmacy Directory**. You can also find information on our website at myUHC.com/CommunityPlan.

Specialized pharmacies

Some 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 (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Customer Service at 1-844-368-7151 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your **Pharmacy Directory** (myUHC.com/CommunityPlan) or call Customer Service at 1-844-368-7151 (TTY users call 711).

Section 2.2 Our plan’s mail-order service

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

To get order forms and information about filling your prescriptions by mail, please reference your **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 pharmacy order will be delivered to you in no more than 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.

New prescriptions the pharmacy gets directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You can ask for automatic delivery of all new prescriptions at any time by phone or mail.

If you get a prescription automatically by mail that you don't want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

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

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It's important to respond each time you're contacted by the pharmacy to let them know whether to ship, delay, or cancel the new prescription.

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

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 will contact you before shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed. If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 10 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling Optum Rx® at 1-877-889-5802.

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

Please keep your mail order pharmacy informed about the best way(s) to contact you, so the pharmacy can reach you to confirm your order before shipping. You can do this by contacting the mail order pharmacy when you set up your auto refill program and also when you receive notifications about upcoming refill shipments.

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost-sharing may be lower. The plan offers 2 ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your **Pharmacy Directory** (myUHC.com/CommunityPlan) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service at 1-844-368-7151 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in the plan's network

Generally, we cover drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Check first with Customer Service at 1-844-368-7151 (TTY users call 711) to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy in the United States only in these circumstances:

- **Prescriptions for a medical emergency**
  We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Drug List without restrictions, and are not excluded from Medicare Part D coverage.
- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy that provides 24-hour service is not within reasonable driving distance.
- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- If you need a prescription while a patient in an emergency department, provider based clinic, outpatient surgery, or other outpatient setting.
- Any prescriptions filled outside of the United States are not covered.

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 2 for information on how to ask the 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 an in-network pharmacy.

Section 3 Your drugs need to be on the plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

The plan has a **"List of Covered Drugs (Formulary)".** In this **Evidence of Coverage, we call it the Drug List**.

The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug List only shows drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. You can learn more about prescription drug coverage under your Cardinal Care Medicaid benefits by contacting

your Medicaid health plan or Virginia Department of Medical Assistance Services (Medicaid) listed in Chapter 2 of this booklet. Your Cardinal Care Medicaid health plan or Virginia Department of Medical Assistance Services (Medicaid) may also be able to provide a Medicaid Drug List that tells you how to find out which drugs are covered under Medicaid.

We generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and use of the drug for a medically accepted indication. A medically accepted indication is a use of the drug that's either:

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

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

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

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product 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.

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

Drugs that aren't on the Drug List

The plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)
- Medicaid-covered drugs may not be included on this plan's Drug list. If this plan doesn't cover a specific drug, please check your Medicaid Drug list to see if the drug is covered.

Section 3.2 5 "cost-sharing tiers" for drugs on the Drug List

Every drug on our plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

Tier 1 – Preferred Generic - Lower-cost, commonly used generic drugs.

Tier 2 – Generic - Many generic drugs.

Tier 3 – Preferred Brand - Many common brand name drugs, called preferred brands, and some higher-cost generic drugs.

Tier 3 – Covered Insulin Drugs - Covered insulins $0 for each 1-month supply until the catastrophic stage. [1]

Tier 4 – Non-preferred Drug - Non-preferred generic and non-preferred brand name drugs.

Tier 5 – Specialty Tier - Unique and/or very high-cost brand and generic drugs.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

[1] You pay a maximum of $0 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.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

1. Check the most recent Drug List we provided electronically.
2. Visit the plan's website (myUHC.com/CommunityPlan). The Drug List on the website is always the most current.
3. Call Customer Service at 1-844-368-7151 (TTY users call 711) to find out if a particular drug is on the plan's Drug List or ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (myUHC.com/CommunityPlan) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Customer Service at 1-844-368-7151 (TTY users call 711).

Section 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

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 health care provider, and different restrictions or cost-sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Customer Service at 1-844-368-7151 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to**

waive the restriction for you, you need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you (go to Chapter 9).

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.

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan based on specific criteria before we agree to cover the drug for you. 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 this approval, your drug might not be covered by the plan. Our plan's prior authorization criteria can be obtained by calling Customer Service at 1-844-368-7151 (TTY users call 711) or on our website myUHC.com/CommunityPlan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, the plan may require you to try Drug A first. If Drug A doesn't work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **"step therapy".** Our plan's step therapy criteria can be obtained by calling Customer Service at 1-844-368-7151 (TTY users call 711) or on our website myUHC.com/CommunityPlan.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our drug list (formulary) or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage
- The drug is covered, but in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be
- **If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.**

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug
- You can change to another drug
- You can ask for an **exception** and ask the plan to cover the drug or remove restrictions from the drug

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on the plan's Drug List** OR **is now restricted in some way.**

- **If you're a new member**, we'll cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- **If you were in the plan last year**, we'll cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for at least a 30-day supply. If your prescription is written for fewer days, we'll allow multiple fills to provide up to at least a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in the plan for more than 90 days and live in a long-term care facility and need a supply right away:**
  We'll cover at least a 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For 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're prescribed a drug that's not on our Drug List or your ability to get your drugs is restricted in some way, you're 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.

For questions about a temporary supply, call Customer Service at 1-844-368-7151 (TTY users call 711).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by the plan may work just as well for you. Call Customer Service at 1-844-368-7151 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask the plan to cover a drug even though it's not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you're a current member and a drug you take will be removed from the formulary or restricted in some way for next year, we'll tell you about any change before the new year. You can ask for an exception before next year and we'll give you an answer 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.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Customer Service at 1-844-368-7151 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 Specialty Tier aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

Section 6 Our Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**
- **Move a drug to a higher or lower cost-sharing tier**
- **Add or remove a restriction on coverage for a drug**
- **Replace a brand name drug with a generic version of the drug**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product**

We must follow Medicare requirements before we change the plan's Drug List.

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
  - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these immediate changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List.**
  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We'll tell you at least 30 days before we make the change or tell you about the change and cover at least a 30-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you're taking.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition,

or asking for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you've been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

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

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.
We won't tell you about these types of changes directly during the current plan 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 to drugs you take that will impact you during the next plan year.

Section 7 Types of drugs we don't cover

Some kinds of prescription drugs are excluded. This means Medicare doesn't pay for these drugs.

If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B
- Our plan can't cover a drug purchased outside the United States or its territories
- Our plan can't cover **off-label** use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. **Off-label** use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs listed below aren't covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. Please check your Medicaid Drug list to see if any of the drugs listed below are covered:

- Non-prescription drugs (also called over-the-counter drugs)
- 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 treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you **get Extra Help from Medicare** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. (Go to the plan's Drug List or call Customer Service at 1-844-368-7151 (TTY users call 711) for more information.) If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

Section 8 How to fill a prescription

To fill your prescription, provide your UnitedHealthcare member ID information (which can be found on your member ID card) at the network pharmacy you choose. The network pharmacy will automatically bill the plan for your drug.

If you don't have your plan membership information with you, you or the pharmacy can call the plan to get the information, or you can ask the pharmacy to look up our 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**. You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask the plan for reimbursement.

Section 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all our rules for coverage described in this chapter.

Section 9.2 As a resident in a long-term care (LTC) facility

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it's part of our network.

Check your **Pharmacy Directory** (myUHC.com/CommunityPlan) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Customer Service at 1-844-368-7151 (TTY users call 711). If you're in an LTC facility, we

must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also get 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.

Section 9.4 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

Section 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition

- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we'll work with your provider to correct the problem.

Section 10.1 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 prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, 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 be:

- Requiring you to get all your 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 prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other 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 confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) programs to help members manage their medications

We have programs that can help our members with complex health needs. One program is called a Medication Therapy Management (MTM) program. These programs are voluntary and free. A team of pharmacists and doctors developed the programs for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about these programs, contact Customer Service at 1-844-368-7151 (TTY users call 711).

Section 11 Your Part D Explanation of Benefits (EOB) explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-pocket costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and 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).
- **Total drug costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month we'll send you a Part D EOB. The Part D EOB includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.

- **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 displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost-sharing for each prescription claim, if applicable.

Section 11.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here's how you can help us keep your information correct and up to date:

- **Show your UCard every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
  - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
  - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
  - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
  - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others 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 charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Customer Service at 1-844-368-7151, TTY 711. You can also view your EOB on our website at myUHC.com/CommunityPlan. Be sure to keep these reports.

Chapter 6:
What you pay for Part D drugs

?

What you pay for your Part D prescription drugs

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. As a member of UHC Dual Complete VA-Y001 (HMO-POS D-SNP) getting “Extra Help” from Medicare, you don’t pay anything for covered Part D drugs. Your yearly deductible is $0 and you pay nothing for Part D drugs covered by our plan. Some covered drugs are limited to a 30-day supply.

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

Important message about what you pay for vaccines – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s Drug List. Our plan covers most adult 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.

Your membership in our plan will not be affected by your Extra Help. You’ll get the same coverage as someone not getting Extra Help.

What is Extra Help?

The Extra Help program is offered by the Social Security Administration. It helps you save on prescription drug costs. This means you get help paying your prescription drug plan’s monthly premium, yearly deductible, and copays or coinsurance.

Can the amount I pay for covered Part D drugs change throughout the year?

The amount you pay will stay the same throughout the year.

See Chapter 2 section 7 for more information about Extra Help and other programs that help people pay for their prescription drugs.

Chapter 7:

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

Section 1 Situations when you should ask us to pay our share for covered services or drugs

Our network providers bill our plan directly for your covered services and drugs – you shouldn't get a bill for covered services or drugs. If you get a bill for the full cost of medical care or drugs you got, send this bill to us so that we can pay it. When you send us the bill, we'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly.

If you have already paid for a Medicare service or item covered by our plan, you can ask our plan to pay you back (paying you back is often called reimburse you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter. When you send us a bill you've already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got emergency or urgently needed medical care from a provider who's not in our plan's network**

   Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill our plan.

   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us this bill, along with documentation of any payments you already made.

- If the provider is owed anything, we'll pay the provider directly.
- If you already paid more than your share of the cost for the service, we'll determine 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 you think you shouldn't pay

Network providers should always bill our plan directly. But sometimes they make mistakes and ask you to pay more than your share of the cost.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made. Ask us to pay you back for the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

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

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.5 to learn about these circumstances. We may not pay you back the

difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have our UCard with you

If you don't have our UCard with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us 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 cost for a prescription in other situations

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's **Drug List,** or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost of the drug. 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.

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 health plan ID card. This ensures timely coordination of care and access to support.

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

- Pay your bill at the time it is received. We will reimburse you for the difference between the amount of your bill and your cost share for the services as outlined in Chapter 4 and the Exclusions sections of this document.
- Save all of your receipts and send us copies when you ask us to reimburse you. In some situations, we may need to get more information from you or the provider who rendered services to you in order to pay you back for our share of the cost.
- If you are being asked to pay your bill for worldwide emergency services and are unable to make the payment, please call 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.

Section 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipt(s) for your records.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website (**myUHC.com/CommunityPlan**) or call Customer Service and ask for the form.

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

  Part D Prescription drug payment requests:

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

Medical claims payment requests:
UnitedHealthcare
P.O. Box 5220
Kingston, NY 12402-5220

You must submit your Part C (medical) claim to us within 12 months of the date you got the service, item, or Part B drug.

You must submit your Part D (prescription drug) claim to us within 36 months of the date you got the service, item, or drug.

Section 3 We'll consider your request for payment and say yes or no

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost for the service or drug. If you have already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide that the medical care or drug is **not** covered, or you did **not** follow all the rules, we won't pay for our share of the cost of the care or drug. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

Chapter 8:

Your rights and responsibilities

Section 1	Our plan must honor your rights and cultural sensitivities
Section 1.1	**You have a right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities. We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)**

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service number at 1-844-368-7151 for additional information (TTY users should call 711).

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. Se nos exige que le proporcionemos la información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener más información de nuestra parte de una forma que le resulte conveniente, llame al número de Servicio al Cliente al 1-844-368-7151 (los usuarios de TTY deben llamar al 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost-sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost-sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Customer Service (phone numbers are printed on the cover of this booklet). You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Sección 1.1 Usted tiene derecho a recibir información sobre la organización, sus servicios, sus profesionales médicos y proveedores, además de los derechos y las responsabilidades de los miembros. Debemos proporcionar la información de una forma que le resulte conveniente y de acuerdo con sus sensibilidades culturales (en otros idiomas además del inglés, en braille, en letra grande o en otros formatos alternativos, etc.)

Nuestro plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se presten de una manera culturalmente competente y estén a disposición de todos los miembros, incluidos aquellos que tienen un dominio limitado del inglés, habilidades limitadas de lectura, discapacidad auditiva o aquellos que tienen distintos orígenes culturales y étnicos. Los ejemplos de cómo un plan puede cumplir estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traducción, servicios de interpretación, teletipos o conexión al servicio de TTY (teléfono de texto o teletipo).

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. Se nos exige que le proporcionemos la información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener más información de nuestra parte de una forma que le resulte conveniente, llame al número de Servicio al Cliente al 1-844-368-7151 (los usuarios de TTY deben llamar al 711).

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service number at 1-844-368-7151 for additional information (TTY users should call 711).

Nuestro plan debe proporcionar a las mujeres que son miembros la opción de acceso directo a un especialista en salud de la mujer dentro de la red para recibir servicios para el cuidado de la salud preventivos y de rutina de la mujer.

Si los proveedores dentro de la red de nuestro plan para una especialidad no están a su disposición, nuestro plan tiene la responsabilidad de encontrar proveedores de especialidades fuera de la red para que le proporcionen el cuidado que necesita. En este caso, usted solo pagará el costo compartido que corresponde dentro de la red. Si se encuentra en una situación en la que no hay especialistas dentro de la red de nuestro plan que presten un servicio que necesita, llame a nuestro plan para obtener información sobre dónde visitar para recibir este servicio a un costo compartido igual que si se tratara de uno dentro de la red.

Si tiene alguna dificultad para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, consultar a un especialista en salud de la mujer o encontrar un especialista de la red, llame a Servicio al Cliente para presentar una queja formal (los números de teléfono aparecen en la portada de esta guía). También puede presentar una queja ante Medicare si llama al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services and drugs

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from our plan's network of providers, **within a reasonable amount of time**. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

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 you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a Notice of Privacy Practice, that talks about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, we're required to get written permission from you or someone you've given legal power to make decisions for you first.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
  - We're required to release health information to government agencies that are checking on quality of care.
  - Because you're a member of our plan through Medicare, we're required to give Medicare your health information including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Customer Service at 1-844-368-7151 (TTY users call 711).

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 1-844-368-7151, or TTY/RTT 711.
- **To Submit a Written Request.** Mail to:

  UnitedHealthcare 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 UCard** or contact the UnitedHealth Group Customer Call Center at 1-844-368-7151, or TTY/RTT 711.

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[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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Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. We may also call you occasionally to let you know about other Medicare products and services we offer. Call Customer Service if you want to opt out of receiving these calls or want any of the following kinds of information:

If you want any of the following kinds of information, call Customer Service at 1-844-368-7151 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.**
  - You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices **in a way that you can understand.**

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means **if you want to**, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service for assistance in locating an advanced directive form.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can 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 know ahead of time that you're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed?

If you sign an advance directive, and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the appropriate state-specific agency, for example, your State Department of Health. See Chapter 2, Section 3 for contact information regarding your state-specific agency.

Section 1.6 You have a right to voice complaints or appeals about the organization or the care it provides. You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do.

Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we're required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected, and it's not about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Customer Service at 1-844-368-7151 (TTY users call 711)**.
- **Call your local SHIP at 1-800-552-3402**.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

Section 1.8 You have a right to make recommendations regarding the organization's member rights and responsibilities policy. How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Service at 1-844-368-7151 (TTY users call 711)**.

- For information on the quality program for your specific health plan, call Customer Service. You can also access this information online at uhc.com/medicare/resources.html. Open the Additional Medicare information and forms section and select Find information. Then select Other resources and plan information and then Commitment to quality.
- **Call your local SHIP at 1-800-552-3402**.
- Contact **Medicare**.
  - Visit medicare.gov to read the publication Medicare Rights & Protections (available at: (Medicare Rights & Protections)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

Section 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Service at 1-844-368-7151 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this **Evidence of Coverage** to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show your UCard and Medicaid card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For most Plan members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan.
  - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.

- If you're required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to stay a member of our plan.
- **If you move outside our plan service area, you can't stay a member of our plan.**
- **If you move within our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- If you move, tell Social Security (or the Railroad Retirement Board).

Chapter 9:
If you have a problem or complaint (coverage decisions, appeals, complaints)

Section 1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you are having:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 3 will help you identify the right process to use and what you should do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

- Uses simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “integrated organization determination” or “coverage determination” or “at-risk determination” and “independent review organization” instead of “Independent Review Entity.”
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

Section 2 Where to get more information and personalized help

We’re always available to help you. Even if you have a complaint about our treatment of you, we’re obligated to honor your right to complain. You should always call customer service at 1-844-368-7151 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn’t connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program isn't connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit www.Medicare.gov.

You can get help and information from Medicaid

For more information and help in handling a problem, you can also contact Virginia Department of Medical Assistance Services (Medicaid). Here are two ways to get information directly from Virginia Department of Medical Assistance Services (Medicaid):

- You can call 1-855-242-8282. TTY users should call 711.
- You can visit the Virginia Department of Medical Assistance Services (Medicaid) website (http://www.dmas.virginia.gov/).

Section 3 Understanding Medicare and Medicaid complaints and appeals

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

Sometimes the Medicare and Medicaid processes are not combined. In those situations, you use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in Section 6.4. of this chapter, "Step by step: How a Level 2 Appeal is done."

Problems about your benefits

Section 4 Which process to use for your problem

If you have a problem or concern, read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Medicaid**.

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 5, A guide to coverage decisions and appeals.**

No.

Go to **Section 11, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Section 5 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems about 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 Medicare Part B drugs as medical care. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think that you need. In limited circumstances a request for a coverage decision will be dismissed, 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 a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can appeal the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

Under certain circumstances, you can ask for an expedited or fast appeal of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision. 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 to see if we properly followed the rules.

When we have completed the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, 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 Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to Section 6.4 of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 7.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 10 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 5.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Customer Service at 1-844-368-7151 (TTY users call 711).**
- Get free help from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer Service at 1-844-368-7151 (TTY users call 711) and ask for the Appointment of Representative form. (The form is also available at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
  - For medical care, your doctor or other health care provider can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it'll be automatically forwarded to Level 2.
    - If your doctor or other health provider asks that a service or item that you're already getting be continued during your appeal, you may need to name your doctor or other prescriber as your representative to act on your behalf.

- For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.

- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or another person to be your representative, call Customer Service at 1-844-368-7151 (TTY users call 711) and ask for the Appointment of Representative form. (The form is also available at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations in this chapter:

- **Section 6**: Medical care: How to ask for a coverage decision or make an appeal
- **Section 7**: Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 8**: How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 9**: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (**Applies only to these services:** home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Customer Service at 1-844-368-7151 (TTY users call 711). You can also get help or information from your SHIP.

Section 6 Medical care: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the **medical benefits chart**. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan won't approve the medical care your doctor or other health care provider wants to give you, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You got medical care that you believe our plan should cover, but we have said we won't pay for this care. **Make an appeal. Section 6.3.**
4. You got and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 8 and 9. Special rules apply to these types of care.

Section 6.2 How to ask for a coverage decision

Legal Terms	A coverage decision that involves your medical care is called an **organization determination.** A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days or when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally

made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may **only ask** for coverage for medical items and/or services (not requests for payment for items and/or services already got).
- You can get a fast coverage decision **only** if using the standard deadlines **could cause serious harm to your health or hurt your ability to function.**

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request **for a medical item or service** that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a **Part B drug**, we'll give you an answer **within 72 hours** after we get your request.

- **However,** 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we shouldn't take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 11 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. (Go to Section 11 for information on complaints.) We'll call you as soon as we make the decision.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 6.3 How to make a Level 1 appeal

Legal Terms	An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.

- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We will continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

Step 3: We consider your appeal, and we give you our answer.

- When we review your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, 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 us to.
  - 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 take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
  - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your **health** condition requires us to.
  - However, 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 11 for information on complaints.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days, or within 7 calendar days if your request is for a Medicare Part B prescription drug, after we receive your appeal.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**
- If we say no to part or all of what you asked for, we will send you a letter.
  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
  - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 The Level 2 appeal process

Legal Term	The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. 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.

- If your problem is about a service or item that is usually covered by Medicare, we will 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 is usually covered by Medicaid, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be covered by both Medicare and Medicaid, you will automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to Section 6.3 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that is usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after receiving the plan's decision letter.

If your problem is about a service or item Medicare usually covers:

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to the independent review 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 the information about your appeal.

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

- For the fast appeal the independent review organization must give you an answer to your Level 2 appeal within 72 hours of when it gets 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 Part B drug.

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

- For a standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal within 7 calendar days of when it gets 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 Part B drug.

Step 2: The independent review organization gives you its 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 the plan receives 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 shouldn't 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 that:
  - Explains the decision.

- Lets you know about your 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.
- Tells 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.

If your problem is about a service or item Medicaid usually covers:

Step 1: You can ask for a Fair Hearing with the state.

- Level 2 of the appeals process for services that are usually covered by Medicaid is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

Step 2: The Fair Hearing office gives you their answer.

The Fair Hearing office will tell you their decision in writing and explain the reasons for it.

- **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 receive the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal**, 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.”)

If the decision is no for all or part of what I asked for, can I make another appeal?

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

See **Section 10** of this chapter for more information on your appeal rights after Level 2.

Section 6.5 If you're asking us to pay you back for our share of a bill you got for medical care

If you have already paid for a Medicaid service or item covered by our plan, ask our plan to pay you back (reimburse you). It is your right to be paid back by our plan whenever you've paid for medical services or drugs that are covered by our plan. When you send us a bill you already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is **not** covered, or you did **not** follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 6.3. For appeals concerning reimbursement, note:

- We must give you our answer within 30 calendar days after we get your appeal. If you're asking us to pay you back for medical care you have already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the health care provider within 60 calendar days.

Section 7 Part D drugs: How to ask for a coverage decision or make an appeal

Section 7.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs, go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say drug in the rest of this section, instead of repeating covered outpatient prescription drug or Part D drug every time. We also use the term Drug List instead of List of Covered Drugs or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's **Drug List. Ask for an exception. Section 7.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first)**. Ask for an exception. Section 7.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier **Ask for an exception. Section 7.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4**

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 ask for an appeal.

Section 7.2 Asking for an exception

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

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

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to all of our drugs. Some covered drugs are limited to a 30-day supply. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our **Drug List**. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our plan's Drug List is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
   - If our **Drug List** contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
   - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
   - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
   - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
   - You cannot ask us to change the cost-sharing tier for any drug in Tier 5 Specialty Tier.
   - If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting 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 typically includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective as the drug you're asking for and wouldn't cause more side effects or other health problems, we generally **won't** approve your request for an exception. If you ask us for a tiering exception, we generally won't approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan 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 request, you can ask for another review by making an appeal.

Section 7.4 How to ask for a coverage decision, including an exception

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

Step 1: Decide if you need a "standard coverage decision" or a "fast coverage decision."

"Standard coverage decisions" are made **within 72 hours** after we receive your doctor's statement. **"Fast coverage decisions"** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a "fast coverage decision." To get a fast coverage decision, you must meet two requirements:

- You must be asking for a **drug you have not yet received**. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could **cause serious harm to your health or hurt your ability to function.**
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.

- Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
- Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website (myUHC.com/CommunityPlan). Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 tells how you can give written permission to someone else to act as your representative.

- If you're asking for an exception, provide the supporting statement, which is the medical reason for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said **no**. We will also tell you how you can appeal.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.

- For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have 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're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Section 7.5 How to make a Level 1 appeal

Legal Terms	An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."** A "fast appeal" is also called an **"expedited redetermination."**

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal.**

- **For standard appeals, submit a written request.** Chapter 2 has contact information.

- **For fast appeals either submit your appeal in writing or call us at 1-844-368-7151.** Chapter 2 has contact information.

- **We must accept any written request,** including a request submitted on the CMS Model Redetermination Request Form, which is available on our website (myUHC.com/CommunityPlan). Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and we give you our answer.

- When we review your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all 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

- For fast appeals, 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 us to.
  - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7.6 explains the Level 2 appeals process.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have 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're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 7.6 How to make a Level 2 appeal

Legal Term	The formal name for the Independent Review Organization is the Independent Review Entity. It is sometimes called the IRE.

The **independent review organization is an independent organization hired by Medicare**. 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.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If our plan says no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization.
- You must make your appeal request within 65 calendar days from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an at-risk determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information about your appeal to the independent review organization. This information is called your case file. **You have the right to ask us for a copy of your case file.**

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for "fast" appeal

- If your health requires it, ask the independent review organization for a "fast appeal."
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you their answer.

For "fast" appeals

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For "standard" appeals

- **If the independent review organization says yes to part or all of your request for coverage, we must provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the independent review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called upholding the decision. It's also called turning down your appeal.) In this case, the independent review organization will send you a letter that:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 explains the process for Level 3, 4, and 5 appeals.

Section 8 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **"discharge date."**
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells about your rights

Within two calendar days of being admitted to the hospital, you will be given a written notice called **An Important Message from Medicare about Your Rights**. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service at 1-844-368-7151 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **ask for an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.
3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Customer Service at 1-844-368-7151 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048). You can also see the notice online at cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Section 8.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Customer Service at 1-844-368-7151 (TTY users call 711). Or, call your State Health Insurance Assistance Program (SHIP) for personalized help. Virginia Insurance Counseling and Assistance Program (VICAP) 1-800-552-3402, TTY users call 711. SHIP contact information is also available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (**An Important Message from Medicare About Your Rights**) tells you how to reach this organization. Or, find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge.**
  - If you meet this deadline, you may stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.
  - If you do **not** meet this deadline, contact us. If you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the

reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service at 1-844-368-7151 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048. Or you can get a sample notice online at cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (we will call them the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says **yes**, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says **no**, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says **no** to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said **no** to your appeal, **and** you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you're going to Level 2 of the appeals process.

Section 8.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization 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.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.

- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 explains more about Levels 3, 4, and 5 of the appeals process.

Section 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying our share of the cost for your care.**

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 9.1 We'll tell you in advance when your coverage will be ending

Legal Term	**"Notice of Medicare Non-Coverage."** It tells you how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

Section 9.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you received (Notice of Medicare Non-Coverage) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term	**"Detailed Explanation of Non-Coverage."** Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review the information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say **yes** to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say **no**, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say **no** to your Level 1 appeal – **and** you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 9.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said **no** to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 10 Taking your appeal to Level 3, 4, and 5

Section 10.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal: An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
  - If we decide **not** to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will 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 medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, 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) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process may or may not be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal: A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

Section 10.3 Appeal Levels 3, 4, and 5 for Part D Drug Requests

This section may be appropriate for you if you have 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 have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal: An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, 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) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal: A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

The complaint process is only used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	Has someone been rude or disrespectful to you? Are you unhappy with our Customer Service? Do you feel you are being encouraged to leave the plan?
Waiting times	Are you having trouble getting an appointment, or waiting too long to get it? Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Customer Service or other staff at our plan? Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	Did we fail to give you a required notice? Is our written information hard to understand?
Timeliness (These types of complaints are all related to the **timeliness** of our actions related to coverage decisions and appeals)	If you have asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms	A **"complaint"** is also called a **"grievance."** **"Making a complaint"** is also called **"filing a grievance."** **"Using the process for complaints"** is also called **"using the process for filing a grievance."** A **"fast complaint"** is also called an **"expedited grievance."**

Section 11.3 You can also make complaints about quality of care to the Quality Improvement Organization

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- We must receive your complaint within 60 calendar days of the event or incident you are complaining about. 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 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. 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 a 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.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will 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.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint".** If you have a "fast complaint," it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about **quality of care**, you also have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.**
- The Quality Improvement Organization 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. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 11.5 You can also tell Medicare and Medicaid about your complaint

You can submit a complaint about UHC Dual Complete VA-Y001 (HMO-POS D-SNP) directly to Medicare. To submit a complaint to Medicare, go to medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this booklet).

Chapter 10:
Ending membership in our plan

Section 1 Ending your membership in our plan

Ending your membership in the plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you **want** to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and you'll continue to pay your cost share until your membership ends.

Section 2 When can you end your membership in our plan?

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare **with** a separate Medicare drug plan,
- Original Medicare **without** a separate Medicare drug plan (If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable prescription drug coverage for a continuous period of 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Call your State Medicaid Office at 1-855-242-8282 to learn about your Medicaid plan options.

- Other Medicare health plan options are available during the **Open Enrollment Period**. Section 2.2 tells you more about the Open Enrollment Period.
- Your membership will usually end on the first day of the month after we get your request to change our plan. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
- Another Medicare health plan, with or without drug coverage.
- Original Medicare **with** a separate Medicare drug plan.
- Original Medicare **without** a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

If you get Extra Help from Medicare to pay for your drug coverage costs: 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 opt out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make **one** change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period.**

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit Medicare.gov.

- Usually, when you move.
- If you have Medicaid.
- If you're eligible for Extra Help paying for Medicare drug coverage.
- If we violate our contract with you.
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital.

Note: If you're in a drug management program, you may only be eligible for certain Special Enrollment Periods. Chapter 5, Section 10 tells you more about drug management programs.

Note: Section 2.1 tells you more about the special enrollment period for people with Medicaid.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage.
- Original Medicare **with** a separate Medicare drug plan.
- Original Medicare **without** a separate Medicare drug plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Your membership will usually end on the first day of the month after we get your request to change our plan.

If you get Extra Help from Medicare to pay for your drug coverage costs: 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 opt out of automatic enrollment.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Customer Service at 1-844-368-7151 (TTY users call 711).**
- Find the information in the **Medicare & You 2026** handbook.

- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan.	Enroll in the new Medicare health plan You'll automatically be disenrolled from our plan when your new plan's coverage starts.
Original Medicare **with** a separate Medicare drug plan.	Enroll in the new Medicare drug plan You'll automatically be disenrolled from our plan when your new drug plan's coverage starts.
Original Medicare **without** a separate Medicare drug plan.	**Send us a written request to disenroll** or visit our website to disenroll online. Call Customer Service at 1-844-368-7151 (TTY users call 711) if you need more information on how to do this. You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. You'll be disenrolled from our plan when your coverage in Original Medicare starts.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.
For questions about your Medicaid benefits, contact Virginia Department of Medical Assistance Services (Medicaid), at 1-855-242-8282, 8 a.m. - 6 p.m. ET, Monday - Friday. TTY users call 711. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

Section 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership ends, and your new Medicare and Medicaid coverage starts, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**

- **If you're hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you're discharged (even if you're discharged after your new health coverage starts).**

Section 5 We must end our plan membership in certain situations

We must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you're no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. We must notify you in writing that you have a 6 month grace period to regain eligibility before you are disenrolled. For more information on the grace period and how it may affect your costs under this plan, please see Chapter 4, Section 1.1.
- If you do not pay your medical spend down, if applicable.
- If you move out of our service area.
- If you're away from our service area for more than 6 months.
  - If you move or take a long trip, call Customer Service at 1-844-368-7151 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- 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. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your UCard to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Customer Service at 1-844-368-7151 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Our plan isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the 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.

Chapter 11:
Legal notices

Section 1 Notice about governing law

The principal law that applies to this **Evidence of Coverage** document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

Section 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, 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 the Virginia Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call us at Customer Service 1-844-368-7151 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. 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.

Section 4 Third party liability and subrogation

If you suffer an illness or injury for which any third party is alleged to be liable or responsible due to any negligent or intentional act or omission causing illness or injury to you, you must promptly notify us of the illness or injury. We will send you a statement of the amounts we paid for services provided in connection with the illness or injury. If you recover any sums from any third party, we shall be reimbursed out of any such recovery from any third party for the payments we made on your behalf, subject to the limitations in the following paragraphs.

1) **Our payments are less than the recovery amount**. If our payments are less than the total recovery amount from any third party (the "recovery amount"), then our reimbursement is computed as follows:
   a) **First:** Determine the ratio of the procurement costs to the recovery amount (the term "procurement costs" means the attorney fees and expenses incurred in obtaining a settlement or judgment).
   b) **Second:** Apply the ratio calculated above to our payment. The result is our share of procurement costs.
   c) **Third:** Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.
2) **Our payments equal or exceed the recovery amount.** If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.
3) **We incur procurement costs because of opposition to our reimbursement.** If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
   a) Our payments made on your behalf for services; or
   b) the recovery amount, minus the party's total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment or verdict. You may be required by us and you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

Section 5 Member liability

In the event we fail to reimburse a provider's charges for covered services, you will not be liable for any sums owed by us. Neither the plan nor Medicare will pay for non-covered services.

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

Section 6 Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your plan, unless otherwise listed as a covered service. A service is "reasonable and necessary" if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
  2. Furnished in a setting appropriate to the patient's medical needs and condition;
  3. Ordered and furnished by qualified personnel;
  4. One that meets, but does not exceed, the patient's medical need; and
  5. At least as beneficial as an existing and available medically appropriate alternative.

Section 7 Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership.**

Section 8 Acts beyond our control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, network providers may become unavailable to arrange or provide health services pursuant to this 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 network provider shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

Section 9 Contracting medical providers and network hospitals are independent contractors

The relationships between the plan and network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of the plan. An agent would be anyone authorized to act on the plan's behalf.

Section 10 Technology assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual member, one of our Medical Directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

Section 11 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.

Section 12 Information upon request

As a plan member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals
- The financial condition of UnitedHealthcare Insurance Company or one of its affiliates

Section 13 2026 Enrollee Fraud & Abuse Communication

2026 Enrollee Fraud & Abuse Communication
How you can fight healthcare fraud

Our company is committed to preventing fraud, waste, and abuse in Medicare benefit programs and we're asking for your help. If you identify a potential case of fraud, please report it to us immediately.
Here are some examples of potential Medicare fraud cases:

- A health care provider - such as a physician, pharmacy, or medical device company - bills for services you never got;
- A supplier bills for equipment different from what you got;
- Someone uses another person's Medicare card to get medical care, prescriptions, supplies or equipment;
- Someone bills for home medical equipment after it has been returned;
- A company offers a Medicare drug or health plan that hasn't been approved by Medicare; or
- A company uses false information to mislead you into joining a Medicare drug or health plan.

To report a potential case of fraud in a Medicare benefit program, call UHC Dual Complete VA-Y001 (HMO-POS D-SNP) Customer Service at 1-844-368-7151 (TTY 711), 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization will not take any action against you for reporting a potential fraud case in good faith.

You may also report potential medical or prescription drug fraud cases to the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SafeRx (1-877-772-3379) or to the Medicare program directly at (1-800-633-4227). The Medicare fax number is 1-717-975-4442 and the website is medicare.gov.

Section 14 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.

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

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Benefit period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (Go to 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 substituted for the original biological product at the pharmacy without needing a new prescription (Go to Interchangeable Biosimilar).

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,100 for Medicare-covered Part D drugs during the covered year. During this payment stage, you pay nothing for your Medicare-covered Part D drugs.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Clinical Research Study – A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care

procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles. Coinsurance for in-network services is based upon contractually negotiated rates (when available for the specific covered service to which the coinsurance applies) or Medicare Allowable Cost, depending on our contractual arrangements for the service.

Compendia – Medicare-recognized reference books for drug information and medically accepted indications for Part D coverage.

Complaint – The formal name for making a complaint is filing a grievance. The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2) any fixed copayment amount that a plan requires when a specific service or drug is received; or 3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called coverage decisions in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

Covered Services – The term we use in this EOC to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for

Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Daily cost-sharing rate – A daily cost-sharing rate 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 copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Daily Cost Share applies only if the drug is in the form of a solid oral dose (e.g., tablet or capsule) when dispensed for less than a one-month supply under applicable law. The Daily Cost Share requirements do not apply to either of the following:

1. Solid oral doses of antibiotics.
2. Solid oral doses that are dispensed in their original container or are usually dispensed in their original packaging to assist patients with compliance.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or **Disenrollment –** The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dually Eligible Individuals – A person who is eligible for Medicare and Medicaid coverage.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the person's eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish

emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

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 (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Chapter 4, Section 2.1 under the heading "Home health agency care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day/7 days a week.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for

skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product 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.

Integrated D-SNP – A D-SNP 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 also known as full-benefit dually eligible individuals.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Institutional Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Integrated Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Integrated Organization Determination – The Medicare Advantage Plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs don't count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.) Go to Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and 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).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Allowable Cost – The maximum price of a service for reimbursement purposes under Original Medicare.

Medicare Assignment – In Original Medicare, a doctor or supplier "accepts assignment" when he or she agrees to accept the Medicare-approved amount as full payment for covered services.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental or hearing,

that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – 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.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 1, Section 3.2)

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. "Network providers" have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare (also called the Annual Enrollment Period).

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) **–** Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your

share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-pocket costs – Go to the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service.

Part C – Go to **Medicare Advantage (MA) plan.**

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Point of Service (POS) Plan – As a member of this Point of Service (POS) plan you may receive covered services from network providers. You may also receive covered routine dental services from providers who are not contracted with UnitedHealthcare.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription Drug Benefit Manager – Third party prescription drug organization responsible for processing and paying prescription drug claims, developing and maintaining the drug list (formulary), and negotiating discounts and rebates with drug manufacturers.

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 see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see

any other health care provider.

Prior Authorization – For medical services it means a process where your doctor or treating provider must receive approval in advance before certain medical services will be provided or payable. For certain drugs it means a process where you or your provider must receive approval in advance before certain drugs will be provided or payable. This approval is based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria is posted on our website.

Prosthetics and Orthotics – Medical devices including, 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 practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Real-Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications 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 medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Retail Walk-In Clinic – A provider location that generally does not require appointments and may be a standalone location or located in a retail store, supermarket or pharmacy. Walk-In Clinic Services are subject to the same cost-sharing as Urgent Care Centers. (See the Benefit Chart in Chapter 4)

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan may disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or 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 plan network is temporarily unavailable.

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

Call **1-844-368-7151**

Calls to this number are free. 8 a.m.-8 p.m.: 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. 8 a.m.-8 p.m.: 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 3 of the Evidence of Coverage.

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