Member Handbook 2023

UnitedHealthcare Dual Complete® ONE
(HMO-POS D-SNP)
H7778-002-000

Toll-free **1-844-368-5888**, TTY **711**, or your preferred relay service
8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September

myuhc.com/communityplan

United Healthcare

Y0066_EOC_H7778_002_000_2023_C

January 1–December 31, 2023

Your Medicare and Medical Assistance (Medicaid) Health, Long-Term Services and Supports, and Drug Coverage as a member of UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP)

Member Handbook Introduction

This handbook tells you about your coverage under UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) through December 31, 2023. It explains Medicare and Medical Assistance (Medicaid) health care services, behavioral health coverage, prescription drug coverage, and long-term services and supports (LTSS). LTSS help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the Member Handbook.

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

This UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) plan is offered by UnitedHealthcare. When this **Member Handbook** says "we," "us," or "our," it means UnitedHealthcare. When it says "the plan" or "our plan," it means UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP).

ATTENTION: If you speak another language other than English, language assistance services, free of charge, are available to you. Call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at the number at the bottom of this page. The call is free.

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

To make or change a standing request to get this document, now and in the future, in a language other than English or in an alternate format, call Member Services at the number at the bottom of this page.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

2023 Member Handbook Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Disclaimers

- We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.
- Benefits may change on January 1, 2024.
- The formulary, pharmacy network, and provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.
- Every year, Medicare evaluates plans based on a 5-star rating system.
- Coverage under UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at **irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information on the individual shared responsibility requirement.
- UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) depends on contract renewal.
- We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact **medicare.gov** or **1-800-MEDICARE** to get information on all of your options.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

United Healthcare Community Plan

CB5 (MCOs) (10-2021)

Civil Rights Notice

Discrimination is against the law. UnitedHealthcare Community Plan of Minnesota does not discriminate on the basis of any of the following:

- Race
- Color
- National origin
- Creed
- Religion
- Sexual orientation
- Public assistance status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital status
- Political beliefs
- Medical condition
- Health status
- Receipt of health care services
- Claims experience
- Medical history
- Genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UnitedHealthcare Community Plan of Minnesota. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
Toll Free: **1-844-368-5888**, TTY **711**
Email: **UHC_Civil_Rights@uhc.com**

Auxiliary Aids and Services: UnitedHealthcare Community Plan of Minnesota provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact Member Services at 1-844-368-5888.**

Language Assistance Services: UnitedHealthcare Community Plan of Minnesota provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact Member Services at 1-844-368-5888.**

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UnitedHealthcare Community Plan of Minnesota. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Age
- Disability
- Sex
- Religion (in some cases)

Contact the **OCR** directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601

Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: **ocrmail@hhs.gov**

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Religion
- Creed
- Sex
- Sexual orientation
- Marital status
- Public assistance status
- Disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104

Voice: 651-539-1100
Toll free: 800-657-3704
MN Relay: 711 or 800-627-3529
Fax: 651-296-9042
Email: **Info.MDHR@state.mn.us**

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National origin
- Religion (in some cases)
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
Voice: 651-431-3040 or use your preferred relay service

American Indian Health Statement

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

1-844-368-5888, TTY **711**

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအား အခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကို ခေါ်ဆိုပါ။*

កំណត់សម្គាល់៖ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះ ដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သး. နမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီနၤလၢ တၢ်ကကွဲးကျိုးထံဝဲဒဉ် လံာ်တီလံာ်မိတခါအံၤအဃိ ကိးလီတဲစိနိဉ်ဂ်ၢ် လၢထးအံၤန့ဉ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Chapter 1

Getting started as a member

Introduction

This chapter includes information about UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP), a health plan that covers all of your Medicare and Medicaid services, and your membership in it. It also tells you what to expect and what other information you will get from UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP). Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook.**

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? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section A Welcome to UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP)

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) is a Medicare Advantage Special Needs Plan. A Special Needs Plan has a network made up of doctors, hospitals, pharmacies, providers of long-term services and supports (LTSS), and other providers. It also has care coordinators and care teams to help you manage all of your providers and services. They all work together to provide the care you need.

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) was approved by the State of Minnesota and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of Minnesota Senior Health Options (MSHO).

MSHO is a demonstration program jointly run by Minnesota and the federal government to provide better health care for people who have both Medicare and Medical Assistance (Medicaid). Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medical Assistance (Medicaid) health care services.

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) is run by a private company. Like all Medicare Advantage plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the State of Minnesota to coordinate your Medical Assistance (Medicaid) benefits. We are pleased to be providing your Medicare health care coverage, including your prescription drug coverage.

Section B Information about Medicare and Medical Assistance (Medicaid)

Section B1 Medicare

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).

Section B2 Medical Assistance (Medicaid)

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for LTSS and medical costs. It covers extra services and drugs not covered by Medicare. In Minnesota, Medicaid is called Medical Assistance.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Each state decides:

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

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

Medicare and Minnesota must approve UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) each year. You can get Medicare and Medical Assistance (Medicaid) services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the State of Minnesota approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medical Assistance (Medicaid) services will not be affected.

Section C Advantages of this plan

You will now get all of your covered Medicare and Medical Assistance (Medicaid) services from UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP), including prescription drugs. **You do not pay extra to join this health plan.**

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) will help make your Medicare and Medical Assistance (Medicaid) benefits work better together and work better for you. Some of the advantages include:

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a care coordinator. This is a person who works with you, with UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP), and with your care providers to make sure you get the care you need.
- You will be able to direct your own care with help from your care team and care coordinator.
- The care team and care coordinator will work with you to come up with a care plan specifically designed to meet your health needs. The care team will be in charge of coordinating the services you need. This means, for example:
  - Your care team will make sure your doctors and other providers know about all medicines you take so they can reduce any side effects.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

– Your care team will make sure your test results are shared with all of your doctors and other providers.

Section D UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP)'s service area

Our service area includes St. Louis county in Minnesota.

Only people who live in our service area can get UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP).

If you move outside of our service area, you cannot stay in this plan. Refer to Chapter 8 (Your rights and responsibilities) for more information about the effects of moving out of our service area.

Section E What makes you eligible to be a plan member

You are eligible for our plan as long as:

- you live in our service area, **and**
- you have both Medicare Part A and Medicare Part B, **and**
- you are eligible for Medical Assistance (Medicaid), **and**
- you are a United States citizen or are lawfully present in the United States, **and**
- you are age 65 or over.

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

When you first join the plan, you will get a health risk assessment within the first 30 days.

You will automatically be assigned a care coordinator when you first join the plan. Your care coordinator will send you their contact information within 10 days of enrollment. Within 30 days of enrollment, the care coordinator conducts a health risk assessment (HRA) with you. The health risk assessment helps the care coordinator identify risks you may be currently experiencing, prioritizes care needs, and facilitates interventions that can prevent or minimize current health problems or complications.

If UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) is new for you, you can keep using the doctors you use now for up to 120 days for certain reasons. For more information, refer to Chapter 3 (Using the plan's coverage for your health care and other covered services).

After 120 days, you will need to use doctors and other providers in the UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) network. A network provider is a provider who works with the

health plan. Refer to Chapter 3 (Using the plan's coverage for your health care and other covered services) for more information on getting care.

Section G Your care plan

Your care plan is the plan for what health services you will get and how you will get them.

After your health risk assessment, your care coordinator will meet with you to talk about what health services you need and want. Together, you and your care coordinator will make your care plan along with input from your care team.

Every year, your care coordinator will work with you to update your care plan if the health services you need and want change.

Section H UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) monthly plan premium

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) does not have a monthly plan premium.

Section I The Member Handbook

This **Member Handbook** is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)), or call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

You can ask for a **Member Handbook** by calling Member Services at **1-844-368-5888**. You can also refer to the **Member Handbook** at **myuhc.com/communityplan** or download it from this website.

The contract is in effect for the months you are enrolled in UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) between January 1, 2023 and December 31, 2023.

Section J Other important information you will get from us

You should have a UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member ID Card, information about how to access or get a **Provider and Pharmacy Directory**, and information about how to access a **List of Covered Drugs** (Drug List).

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section J1 Your UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member ID Card

Under our plan, you will have one card for your Medicare and Medical Assistance (Medicaid) services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions. Here's a sample card to show you what yours will look like:

If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Medical Assistance (Medicaid) card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7 (Asking us to pay a bill you have gotten for covered services or drugs) to find out what to do if you get a bill from a provider.

Section J2 Provider and Pharmacy Directory

The **Provider and Pharmacy Directory** lists the providers and pharmacies in the UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan.

You can ask for a **Provider and Pharmacy Directory** by calling Member Services at the number at the bottom of this page. You can also find the **Provider and Pharmacy Directory** at **myuhc.com/communityplan** or download it from this website.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Both Member Services and the website can give you the most up-to-date information about changes in our network pharmacies and providers.

Definition of network providers

- UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP)'s network providers include:
  - Doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - Home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medical Assistance (Medicaid).

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

Definition of network pharmacies

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

Section J3 List of Covered Drugs (Drug List)

The plan has a **List of Covered Drugs**. We call it the "Drug List" for short. It tells which prescription drugs are covered by UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP).

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to Chapter 5 (Getting your outpatient prescription drugs through the plan) for more information on these rules and restrictions.

Each year, we will send you information about how to access the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit **myuhc.com/communityplan** or call **1-844-368-5888**.

Section J4 The Explanation of Benefits (EOB)

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

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

The EOB tells you the total amount you, or others on your behalf, have spent on your Medicare Part D prescription drugs and the total amount we have paid for each of your Medicare Part D prescription drugs during the month. The EOB has more information about the drugs you take. Chapter 6 (What you pay for your Medicare and Medical Assistance (Medicaid) prescription drugs) gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB is also available when you ask for one. To get a copy, contact Member Services.

Section K How to keep your membership record up to date

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

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get and how much it will cost you.** Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage, such as from your employer, your spouse's employer or your domestic partner's employer, or workers' compensation
- Any liability claims, such as claims from an automobile accident
- Admissions to a nursing home or hospital
- You get care in an out-of-area or out-of-network hospital or emergency room
- Changes in who your caregiver (or anyone responsible for you) is
- You are part of or become part of a clinical research study (NOTE: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so).

If any information changes, please let us know by calling Member Services at the number at the bottom of this page.

In addition, call your county worker to report these changes:

- Name or address changes
- Admission to a nursing home
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Program ID Card

- New insurance
- New job or change in income

Section K1 Privacy of personal health information (PHI)

The information in your membership record may include personal health information (PHI). Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, refer to Chapter 8 (Your rights and responsibilities).

Chapter 2

Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook.**

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? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section A How to contact UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services

Method	Member services — Contact information
Call	**1-844-368-5888** The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September We have free interpreter services for people who do not speak English.
TTY	**711**, or your preferred relay service. The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September
Write	P.O. Box 30769 Salt Lake City, UT 84130-0769
Website	**myuhc.com/communityplan**

Section A1 Contact Member Services

- With questions about the plan
- With questions about claims, billing or Member ID Cards
- For information about coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services, **or**
    - the amount we will pay for your health care services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
- To make an appeal about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.
  - To learn more about making an appeal, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
- With complaints about your health care

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (refer to Section F below (How to contact the Quality Improvement Organization (QIO)).
- If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
- You can send a complaint about UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) right to Medicare. You can use an online form at **medicare.gov/MedicareComplaintForm/home.aspx**. Or you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, to ask for help. TTY users should call **1-877-486-2048**.
- To learn more about making a complaint about your health care, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

• For information about coverage decisions about your drugs

- A coverage decision about your drugs is a decision about:
  - your benefits and covered drugs, **or**
  - the amount we will pay for your drugs.
- This applies to your Medicare Part D drugs, Medical Assistance (Medicaid) prescription drugs, and Medical Assistance (Medicaid) over-the-counter drugs.
- For more on coverage decisions about your prescription drugs, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

• To make an appeal about your drugs

- An appeal is a way to ask us to change a coverage decision.
- For more on making an appeal about your prescription drugs, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

• With complaints about your drugs

- You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
- If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)
- You can send a complaint about UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) right to Medicare. You can use an online form at **medicare.gov/MedicareComplaintForm/home.aspx**. Or you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, to ask for help. TTY users should call **1-877-486-2048**.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

  - For more on making a complaint about your prescription drugs, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
- To ask for payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to Chapter 7 (Asking us to pay a bill you have gotten for covered services or drugs).
  - We do not allow UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) providers to bill you for services. We pay our providers directly, and we protect you from any charges. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Member Services at the phone number printed at the bottom of this page.
  - If we deny any part of your request, you can appeal our decision. Refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for more on appeals.

Section B How to contact your Care Coordinator

Method	Care Coordinator — Contact information
Call	**1-844-368-5888** The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September We have free interpreter services for people who do not speak English.
TTY	**711**, or your preferred relay service. The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September
Write	P.O. Box 30769 Salt Lake City, UT 84130-0769
Website	**myuhc.com/communityplan**

Section B1 Contact your Care Coordinator

- With questions about your health care
- With questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)
  - You must have a Long-Term Care Consultation (LTCC) done and be found to be eligible to get additional services or support. You can ask to have this assessment in your home, apartment, facility where you live, or another agreed-upon location.
  - Your care coordinator will meet with you and your family to talk about your care needs if you call to ask for a visit.
  - Your care coordinator will give you information about community services, help you find services to stay in your home or community, and help you find services to move out of a nursing home or other facility.
  - Sometimes you can get help with your daily health care and living needs. You might be able to get these services if you need them:
    - Skilled nursing care
    - Physical therapy
    - Occupational therapy
    - Speech therapy
    - Medical social services
    - Home health care

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section C How to contact the Nurseline

Speak to a registered nurse (RN) about your medical concerns and questions.

Method	Nurseline — Contact information
Call	**1-877-440-9407** The call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	**711**, or your preferred relay service. The call is free. 24 hours a day, 7 days a week

Section C1 Contact the Nurseline

- With questions about your health or health care treatment options

Section D How to contact the Behavioral Health Crisis Line

Method	Behavioral Health Crisis Line — Contact information
Call	**1-844-368-5888** The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September We have free interpreter services for people who do not speak English.
TTY	**711**, or your preferred relay service. The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September

Section D1 Contact the Behavioral Health Crisis Line

- With questions about your health or health care treatment options
- With questions about substance use disorder services

If you have questions, please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section E How to contact the State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Minnesota, the SHIP is called the Senior LinkAge Line®.

The Senior LinkAge Line® is not connected with any insurance company or health plan.

Method	Senior LinkAge Line® — Contact information
Call	**1-800-333-2433** The call is free.
TTY	Call the Minnesota Relay Service at **711** or use your preferred relay service. The call is free.
Write	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976
Website	**seniorlinkageline.com**

Section E1 Contact the Senior LinkAge Line®

- With questions about your Medicare health insurance
  - Senior LinkAge Line® counselors can answer your questions about changing to a new plan and help you:
    - understand your rights,
    - understand your plan choices,
    - make complaints about your health care or treatment, **and**
    - straighten out problems with your bills.

Section F How to contact the Quality Improvement Organization (QIO)

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

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Method	Livanta — Contact information
Call	**1-888-524-9900** Monday through Friday, 9:00 a.m.–5:00 p.m. Weekend and Holidays, 11:00 a.m.–3:00 p.m. 24-hour voicemail is available
TTY	**1-888-985-8775** This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
Write	10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
Website	**livantaqio.com**

Section F1 Contact Livanta

- With questions about your health care
  - You can make a complaint about the care you got if you:
    - have a problem with the quality of care,
    - think your hospital stay is ending too soon, **or**
    - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

Section G How to contact 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, or CMS.

Method	Medicare — Contact information
Call	**1-800-MEDICARE (1-800-633-4227)** Calls to this number are free, 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
Website	**medicare.gov** This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has booklets you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, print it out, and send it to you.

Section H How to contact Medical Assistance (Medicaid)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. In Minnesota, the Medicaid program is called Medical Assistance. To find out more about Medical Assistance (Medicaid) and its programs, contact the Minnesota Department of Human Services.

You are enrolled in Medicare and in Medical Assistance (Medicaid). If you have questions about the help you get from Medical Assistance (Medicaid), call the Minnesota Department of Human Services.

Method	Medical Assistance (Medicaid) — Contact information
Call	**1-651-431-2670** (Twin Cities Metro area) Or **1-800-657-3739** (Outside the Twin Cities Metro area) The call is free.
TTY	**1-800-627-3529** (You need special telephone equipment to call this number.) Or **711** or use your preferred relay service (You do not need special telephone equipment to call this number.) These calls are free.
Write	Department of Human Services of Minnesota 444 Lafayette Road North St. Paul, MN 55155
Website	**mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp**

Section I How to contact the Ombudsperson for Public Managed Health Care Programs

The Ombudsperson for Public Managed Health Care Programs works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Ombudsperson for Public Managed Health Care Programs also helps people enrolled in Medical Assistance (Medicaid) with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free. **The Ombudsperson can also help you ask for a state appeal (Medicaid fair hearing with the State).**

Method	Ombudsperson for Public Managed Health Care Programs — Contact information
Call	**1-651-431-2660** (Twin Cities Metro area) Or **1-800-657-3729** (Outside Twin Cities Metro area) The call is free.
TTY	**1-800-627-3529** (You need special telephone equipment to call this number.) Or **711** or use your preferred relay service (You do **not** need special telephone equipment to call this number.) These calls are free.
Fax	**1-651-431-7472**
Write	MN Department of Human Services Ombudsperson for Public Managed Health Care Programs PO Box 64249 St. Paul, MN 55164-0249
Email	dhsombudsman.smhcp@state.mn.us
Website	**mn.gov/dhs/managedcareombudsman**

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section J How to contact the Minnesota Office of Ombudsman for Long Term Care

The Minnesota Office of Ombudsman for Long Term Care is an ombudsman program that helps people learn about nursing homes and other long-term care settings. It also helps solve problems between these settings and residents or their families.

Method	Minnesota Office of Ombudsman for Long Term Care — Contact information
Call	**1-651-431-2555** (Twin Cities Metro area) Or **1-800-657-3591** (Outside Twin Cities Metro area) The call is free.
TTY	**1-800-627-3529** (You need special telephone equipment to call this number.) Or **711** or use your preferred relay service (You do **not** need special telephone equipment to call this number.) These calls are free.
Write	Minnesota Office of Ombudsman for Long Term Care PO Box 64971 St. Paul, MN 55164-0971
Email	mba.ooltc@state.mn.us
Website	**mn.gov/board-on-aging**

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section K Other resources

Section K1 Contact the Railroad Retirement Board (RRB)

The Railroad Retirement Board (RRB) is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions about your benefits from the RRB, contact the agency.

If you get your Medicare through the RRB, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board (RRB) — Contact information
Call	**1-877-772-5772** Calls to this number are free. If you press "0," you may speak with an RRB representative: from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday **and** from 9:00 am to noon on Wednesday. If you press "1," you may access the automated RRB HelpLine and 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 hearing or speaking problems. Calls to this number are **not free.**
Website	**rrb.gov**

Chapter 3

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

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP). It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook.**

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? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section A Information about "services," "covered services," "providers," and "network providers"

Services are health care, long-term services and supports (LTSS), supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. Covered services are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4, Section D.

Providers are doctors, nurses, and other people who give you services and care. The term providers also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and LTSS.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

Section B Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) covers all services covered by Medicare and Medical Assistance (Medicaid). This includes behavioral health and LTSS.

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) will generally pay for the health care and services you get if you follow plan rules. To be covered by our plan:

- The care you get must be a **plan benefit.** This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4, Section D of this handbook.)
- The care must be **medically necessary**. Medically necessary describes the services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, equipment, or drugs meet accepted standards of medical practice.
  - Medically necessary care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:
    - be the services that other providers would usually order
    - help you get better or stay as well as you are
    - help stop your condition from getting worse
    - help prevent and find health problems

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- You must have a network **primary care provider** (PCP) who has ordered the care or has told you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
  - In most cases, your network PCP must give you approval before you can use someone that is not your PCP or use other providers in the plan's network. This is called a **referral**. If you don't get approval, UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) may not cover the services. You don't need a referral for certain specialists, such as women's health specialists. To learn more about referrals, refer to Section D1.
  - You do not need a referral from your PCP for emergency care or urgently needed care or for a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, refer to Section D1.
  - To learn more about choosing a PCP, refer to Section D2.

If your doctor certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

An exception is made for family planning, which is an open access service covered by us through Medical Assistance (Medicaid). Federal and state laws let you choose any provider, even if not in our network, to get certain family planning services. This means by any doctor, clinic, hospital, pharmacy, or family planning office. For more information refer to the "Family Planning Services" section of the Benefits Chart in Chapter 4.

Section C Information about your care coordinator

We use Care Coordinators to make sure you get the best possible care and results. Our care coordinators work with your primary care physician, behavioral health, medical and community service providers to meet your needs. Care Coordination includes developing your care plan, supporting your in your care plan goals and checking with you, your care team, and other plan providers about your care and how it is going.

Section C1 What a care coordinator is

A care coordinator is a person who helps you develop a care plan and coordinates supports and services stated in your care plan. In the development of your care plan, your care coordinator will get to know you and your health and safety concerns. They can help you with your medications, answer health plan questions, supports your health care decisions, help you find providers and arrange home meal delivery and other services for you.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section C2 How you can contact your care coordinator

If you wish to speak to your Care Coordinator, contact them directly with the contact information they provided you or you may call Member Services at **1-844-368-5888**, TTY: **711** (or your preferred relay service), 8 a.m.–8 p.m. 7 days a week, October–March; Monday–Friday, April–September.

Section C3 How you can change your care coordinator

You may request a change in your Care Coordinator if they are not right for you. Please call Member Services at **1-844-368-5888**, TTY **711** (or your preferred relay service), 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September if you need more information or help in choosing a new Care Coordinator.

Section D Care from primary care providers, specialists, other network providers, and out-of-network providers

Section D1 Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

Definition of a "PCP," and what a PCP does for you

A Primary Care Provider (PCP) is a network physician who is selected by you to provide and coordinate your covered services. PCPs are generally physicians specializing in Internal Medicine, Family Practice or General Practice.

Your relationship with your PCP is an important one because your PCP is responsible for the coordination of your health care and is also responsible for your routine health care needs. You may want to ask your PCP for assistance in selecting a network specialist and follow-up with your PCP after any specialist visits. It is important for you to develop and maintain a relationship with your PCP.

Your choice of PCP

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

For a copy of the most recent **Provider and Pharmacy Directory**, or for help in selecting a PCP, call Member Services or visit **myuhc.com/communityplan** for the most up-to-date information about our network providers.

If you do not select a PCP at the time of enrollment, we may pick one for you. You may change your PCP at any time. See "Option to change your PCP" below.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Option to change your PCP

You may change your PCP for any reason, at any time during the year. Also, it's possible that your PCP might leave our plan's network. We can help you find a new PCP if the one you have now leaves our network.

If you want to change your PCP, call Member Services. If the PCP is accepting additional plan members, the change will become effective on the first day of the following month. You will receive a new UnitedHealthcare member ID card that shows this change.

Services you can get without first getting approval from your PCP

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

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or you need immediate care during the weekend).

  NOTE: Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)
- Flu shots, COVID-19 vaccinations, hepatitis B vaccinations, and pneumonia vaccinations.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams
- Additionally, if you are eligible to get services from Indian health providers, you may use these providers without a referral.

Section D2 Care from specialists and other network providers

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

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.

Even though your PCP is trained to handle the majority of common health care needs, there may be a time when you feel that you need to see a network specialist. **You do not need a referral from your PCP to see a network specialist or behavioral/mental health provider.** Although you do not need a referral from your PCP to see a network specialist, your PCP can recommend an appropriate network specialist for your medical condition, answer questions you have regarding a network specialist's treatment plan and provide follow-up health care as needed. For coordination of care, we recommend you notify your PCP when you see a network specialist.

If we are unable to find you a qualified plan network provider, we must give you a standing service authorization for a qualified specialist for any of these conditions:

- A chronic (ongoing) condition;
- A life-threatening mental or physical illness;
- A degenerative disease or disability;
- Any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a service authorization from us when needed, the bill may not be paid. For more information, call Member Services at the phone number printed at the bottom of this page.

Section D3 What to do when a provider leaves our plan

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to make an appeal of our decision. Refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for information about making an appeal.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. You may call Member Services 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 the Benefits Chart in Chapter 4, Section D.

If a provider you choose is no longer in our plan network, you must choose another plan network provider. You may be able to continue to use services from a provider no longer a part of our plan network for up to 120 days for the following reasons:

- An acute condition.
- A life-threatening mental or physical illness.
- A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year, or is likely to result in death.
- A disabling or chronic condition that is in an acute phase.

If your doctor certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

For more information, call Member Services at the phone number printed at the bottom of this page.

Section D4 How to get care from out-of-network providers

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

- We cannot pay a provider who is not eligible to participate in Medicare and/or Medical Assistance (Medicaid).
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

Section E How to get long-term services and supports (LTSS)

Long-Term Services and Supports (LTSS) are services that help people who need assistance doing everyday tasks like getting dressed, making food, taking a bath and doing chores. Most of these services help you stay in your home or meet your needs in a nursing home setting.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

LTSS must be coordinated through your care coordinator. Your care coordinator will assess your needs, determine if you are eligible, and help complete required forms. If you wish to speak to your Care Coordinator, contact them directly with the contact information they provided you or you may call Member Services at **1-844-368-5888**, TTY **711** (or your preferred relay service), 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September.

Section F How to get behavioral health services

Your Care Coordinator can help you connect with behavioral health services in your area. You can also use our online tool to locate network providers in your area or call Member Services at **1-844-368-5888**, TTY **711** (or your preferred relay service).

Section G How to get self-directed care

Section G1 What self-directed care is

Consumer Directed Community Support (CDCS) is a service option available to members who are on or qualify for Elderly Waiver. CDCS gives a member flexibility in service planning and responsibility for self-directing his or her services, including hiring and managing support workers. CDCS may include traditional services and goods, and self-designed services.

Section G2 Who can get self-directed care (for example, if it is limited to waiver populations)

This service option is available to members who are on or qualify for Elderly Waiver.

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

If you are interested in CDCS, please contact your care coordinator.

Section H How to get transportation services

If you need transportation to and from health services that we cover, call **1-888-444-1519** for non-emergent transportation. For emergent transportation, please call **911**. We will provide the most appropriate and cost-effective mode of transportation. We are not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home or if you choose a specialty provider that is more than 60 miles from your home.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section I How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

Section I1 Care when you have a medical emergency

Definition of a medical emergency

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

- serious risk to your health; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need to get approval or a referral first from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide from any provider with an appropriate state license.

Covered services in a medical emergency

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in Chapter 4, Section D. Our plan does not cover emergency medical care that you get outside the United States and its territories.

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

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

Getting emergency care if it wasn't a medical emergency after all

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

However, after the doctor says it was not an emergency, we will cover your additional care only if:

- you use a network provider, **or**
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (Refer to the next section.)

Section I2 Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need to have it treated.

Urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care only if:

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

However, if it is not possible or reasonable to get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

Check your **Provider and Pharmacy Directory** for a list of network Urgent Care Centers or call Member Services at **1-844-368-5888**, TTY **711** (or your preferred relay service), 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September for more information.

Urgently needed care when you are outside the plan's service area

When you are outside the plan's service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

Our plan does not cover urgently needed care or any other non-emergency care that you get outside the United States and its territories.

Section I3 Care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP).

Please visit our website for information on how to obtain needed care during a declared disaster: **myuhc.com/communityplan**.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

Section J What to do if you are billed directly for services covered by our plan

We do not allow UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) providers to bill you for these services. We pay our providers directly, and we protect you from any charges. If a provider sends you a bill instead of sending it to the plan, you can ask us to pay the bill.

You should not pay the bill yourself. If you do, the plan may not be able to pay you back.

If you have paid for your covered services or if you have gotten a bill for covered medical services, refer to Chapter 7 (Asking us to pay a bill you have gotten for covered services or drugs) to learn what to do.

Section J1 What to do if services are not covered by our plan

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) covers all services:

- that are medically necessary, **and**
- that are listed in the plan's Benefits Chart (refer to Chapter 4, Section D), **and**
- that you get by following plan rules.

If you get services that aren't covered by our plan, **you must pay the full cost yourself.**

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

Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

Some services are covered up to a certain limit. If you go over the benefit limit, you will have to pay the full cost to get more of that type of service. Refer to Chapter 4 for specific benefit limits. Call Member Services to find out what the limits are and how close you are to reaching them.

Section K Coverage of health care services when you are in a clinical research study

Section K1 Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study you want to be in, and you express interest, someone who works on the study will contact you. That person will tell you about the study and find out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in any Medicare-approved clinical research study, you do **not** need to tell us or get approval from us or your primary care provider. The providers that give you care as part of the study do **not** need to be network providers.

For more information, please refer to Section D in Chapter 4 of your **Member Handbook**.

We encourage you to tell us before you start participating in a clinical research study. If you plan to be in a clinical research study, you or your care coordinator should contact Member Services to let us know you will be in a clinical trial.

Section K2 Payment for services when you are in a clinical research study

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

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.

- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

If you are part of a study that Medicare has **not approved**, you will have to pay any costs for being in the study.

The cost of any services related to or associated with the clinical trial are not covered by Medical Assistance (Medicaid).

Section K3 Learning more about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (**medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf**). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section L How your health care services are covered when you get care in a religious non-medical health care institution

Section L1 Definition of a religious non-medical health care institution

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

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

Section L2 Getting 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 are against getting medical treatment that is "non-excepted."

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following applies:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from our plan before you are admitted to the facility or your stay will not 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 Benefits Chart in Chapter 4.

Section M Durable medical equipment (DME)

Section M1 DME as a member of our plan

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

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP), however, you usually will not own DME, no matter how long you rent it.

In certain limited situations, we will transfer ownership of the DME item to you. Call Member Services to find out about the requirements you must meet and the papers you need to provide.

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

Section M2 DME ownership when you switch to Original Medicare or another Medicare Advantage plan

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

Note: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the **Medicare & You 2023** handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (**medicare.gov/medicare-and-you**) or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

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

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or a Medicare Advantage plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage plan payments do not count toward the payments you need to make after leaving our plan.**

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

Section M3 Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

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

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

Section M4 Oxygen equipment when you switch to Original Medicare or another Medicare Advantage plan

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

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

- your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

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

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

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

Chapter 4

Benefits Chart

Introduction

This chapter tells you about the services UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

Table of Contents

Section A Your covered services

This chapter tells you what services UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) covers. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5 (Getting your outpatient prescription drugs through the plan). This chapter also explains limits on some services.

Because you get assistance from Medical Assistance (Medicaid), you pay nothing for your covered services as long as you follow the plan's rules. Refer to Chapter 3 (Using the plan's coverage for your health care and other covered services) for details about the plan's rules.

If you need help understanding what services are covered, call your care coordinator and/or Member Services at the number at the bottom of this page.

Section A1 During public health emergencies

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) will follow federal and/or state requirements and allowable flexibilities during a declared public health emergency, as applicable. You can call Member Services at the number at the bottom of this page if you have questions.

Section B Rules against providers charging you for services

We do not allow UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to Chapter 7 (Asking us to pay a bill you have gotten for covered services or drugs) or call Member Services at the number at the bottom of this page.

Section C Our plan's Benefits Chart

The Benefits Chart in Section D tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services.

We will pay for the services listed in the Benefits Chart only when the following rules are met. You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described below.

- Your Medicare and Medical Assistance (Medicaid) covered services must be provided according to the rules set by Medicare and Medical Assistance (Medicaid).

- The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- Medically necessary care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:
  - be the services, supplies, and prescription drugs that other providers would usually order.
  - help you get better or stay as well as you are.
  - help stop your condition from getting worse.
  - help prevent and find health problems.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization. Covered services that need prior authorization are marked in the Benefits Chart 'What you must pay' column.

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

Section C1 Restricted Recipient Program

- The Restricted Recipient Program is for members who have misused health services. This includes getting health services that members did not need, using them in a way that costs more than they should, or using them in a way that may be dangerous to a member's health. UnitedHealthcare will notify members if they are placed in the Restricted Recipient Program.
- If you are in the Restricted Recipient Program, you must get health services from one designated primary care provider, one clinic, one hospital used by the primary care provider, and one pharmacy. UnitedHealthcare may designate other health care providers. You may also be assigned to a home health agency. You may not be allowed to use the personal care assistance choice or flexible use options or consumer directed services.
- You will be restricted to these designated health care providers for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). All referrals to specialists must be from your primary care provider, and received by the UnitedHealthcare Restricted Recipient Program. Restricted recipients may not pay out-of-pocket to use a non-designated provider who is the same provider type as one of their designated providers.

- Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You will not lose eligibility for MHCP because of placement in the program.
- At the end of the 24 months, your use of health care services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility.
- You have the right to appeal placement in the Restricted Recipient Program. You must file an appeal within 60 days from the date on the notice from us. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. A member may request a State Appeal (Medicaid Fair Hearing with the state) after receiving our decision that we will enforce the restriction. Refer to Chapter 9, Section E4, for more information about your right to appeal.
- The Restricted Recipient Program does not apply to Medicare-covered services. If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid medications is not safe, we may limit how you can get those medications. Refer to Chapter 5, Section G3, for more information.

Section D The Benefits Chart

Services that our plan pays for	What you must pay
Abdominal aortic aneurysm screening The plan will pay for a one-time ultrasound screening 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. We may cover additional screenings if medically necessary.	$0
Acupuncture Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing. The plan will pay for up to 12 visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. The plan will pay for an additional 8 sessions if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments for chronic low back pain must be stopped if you don't get better or if you get worse. **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Acupuncture (continued) In addition, the plan will pay for up to 20 units of acupuncture services per calendar year without authorization or ask for prior authorization if additional units are needed for the following: • Acute and chronic pain • Depression • Anxiety • Schizophrenia • Post-traumatic stress syndrome • Insomnia • Smoking cessation • Restless legs syndrome • Menstrual disorders • Xerostomia (dry mouth) associated with the following: – Sjogren's syndrome – radiation therapy • Nausea and vomiting associated with the following: – postoperative procedures – pregnancy – cancer care	$0
Alcohol misuse screening and counseling The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting (refer to the "Substance use disorder services" section of this chart for additional covered benefits).	$0

Services that our plan pays for	What you must pay
Ambulance services Covered ambulance services include air (airplane or helicopter), water, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan. In cases that are not emergencies, the plan may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0 *Authorization is required for Non-emergency Medicare-covered ambulance ground and air transportation.* *Emergency Ambulance does not require authorization.*
Annual wellness visit If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will pay for this once every 12 months. **Note:** You cannot have your first annual checkup within 12 months of your "Welcome to Medicare" preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a "Welcome to Medicare" visit first.	$0
Bone mass measurement The plan will pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will pay for the services once every 24 months or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.	$0
Breast cancer screening (mammograms) The plan will pay for the following services: • One screening mammogram every 12 months • Clinical breast exams once every 24 months We may cover additional services if medically necessary.	$0

Services that our plan pays for	What you must pay
Cardiac (heart) rehabilitation services The plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan pays for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may: • discuss aspirin use, • check your blood pressure, **or** • give you tips to make sure you are eating well. We may cover additional visits if medically necessary.	$0
Cardiovascular (heart) disease testing The plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. We may cover additional tests if medically necessary.	$0
Care coordination The plan pays for care coordination services, including the following: • Assisting you in arranging for, getting, and coordinating assessments, tests, and health and long-term care supports and services • Working with you to develop and update your care plan • Supporting you and communicating with a variety of agencies and persons • Coordinating other services as outlined in your care plan	$0

Services that our plan pays for	What you must pay
Cervical and vaginal cancer screening The plan will pay for the following services: • For all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • For women who have had an abnormal Pap test: one Pap test every 12 months We may cover additional services if medically necessary.	$0
Chiropractic services The plan will pay for the following services: • One evaluation or exam per year • Manual manipulation (adjustment) of the spine to treat subluxation of the spine—up to 24 visits per calendar year, limited to six per month. • Acupuncture for pain and other specific conditions within the scope of practice by chiropractors with acupuncture training or credentialing • X-rays when needed to support a diagnosis of subluxation of the spine **Note:** Our plan does not cover other adjustments, vitamins, medical supplies, therapies, and equipment from a chiropractor.	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Colorectal cancer screening The plan will pay for the following services: • Flexible sigmoidoscopy (or screening barium enema) every 48 months • Fecal occult blood test, every 12 months • Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months • DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, the plan will pay for one screening colonoscopy (or screening barium enema) every 24 months. For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy). We may cover additional screenings if medically necessary.	$0

Services that our plan pays for	What you must pay
Dental services The plan will pay for the following services: Diagnostic services including: • Comprehensive exam once every five years (cannot be performed on same date as a periodic or limited evaluation) • Periodic exam once per calendar year (cannot be performed on same date as a limited or comprehensive evaluation) • Limited (problem-focused) exams once per day (cannot be performed on same date as a periodic or comprehensive oral evaluation or dental cleaning service) • Teledentistry for diagnostic services • Imaging services, limited to: – bitewing once per calendar year – single x-rays for diagnosis of problems four per date of service – panoramic x-rays once every five years and as medically necessary; once every two years in limited situations; or with a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) procedure – full mouth x-rays once every five years and only when provided in an outpatient hospital or freestanding ASC as part of an outpatient dental surgery **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Dental services (continued) Preventive services including: • Dental cleanings limited to two per calendar year; up to four times per year if medically necessary • Fluoride varnish once per calendar year (cannot be performed on the same date as emergency treatment of dental pain service) • Cavity treatment once per tooth per six months (cannot be performed on the same date as fluoride varnish service of emergency treatment of dental pain service) Restorative services including: • Fillings limited to once per 90 days per tooth • Sedative fillings for relief of pain (cannot be performed on same date as emergency treatment of dental pain service) • Endodontics (root canals) on anterior teeth and premolars only and once per tooth per lifetime; retreatment is not covered Periodontics including: • Gross removal of plaque and tartar (full mouth debridement) once every five years (cannot be performed on same date as dental cleaning, comprehensive exam, oral evaluation or periodontal evaluation service) • Scaling and root planing once every two years for each quadrant and (cannot be performed on the same day as dental cleaning or full mouth debridement) • Follow-up procedures (periodontal maintenance every three months/90 days for two years) **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Dental services (continued) Prosthodontics including: • Removable appliances (dentures and partials) once every six years per dental arch • Adjustments, modifications, relines, repairs, and rebases of removable appliances (dentures and partials); repairs to missing or broken teeth are limited to five teeth per 180 days • Replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances • Replacement of partial appliances if the existing partial prosthesis cannot be altered to meet dental needs • Tissue conditioning liners once per appliance • Precision attachments and repairs Oral surgery (limited to extractions, removal of impacted teeth or tooth roots, biopsies and incision and drainage of abscesses) Additional general services including: • Emergency treatment for dental pain once per day **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Dental services (continued) • General anesthesia, deep sedation when provided in an outpatient hospital or freestanding ASC as part of an outpatient dental surgery • Extended care facility/house call in certain institutional settings. These include: nursing facilities, skilled nursing facilities, boarding care homes, Institutes for Mental Diseases (IMD), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD), hospices, Minnesota Extended Treatment Options (METO), and swing beds (a nursing facility bed in a hospital) (cannot be performed on same date as oral hygiene service) • Behavioral management when necessary to ensure that a covered dental service is correctly and safely performed • Oral or intravenous (IV) sedation only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center For additional coverage, please refer to the dental chart located at the end of this chapter. If you choose to get dental benefits from a Federally Qualified Health Center (FQHC) or a state-operated dental clinic, you will have the same benefits that you are entitled to under Medical Assistance (Medicaid). If you are new to our plan and have already started a dental service treatment plan, please contact us for coordination of care.	$0 *Your provider may need to obtain prior authorization for some services*
Depression screening The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals. We may cover additional screenings if medically necessary.	$0

Services that our plan pays for	What you must pay
Diabetes screening The plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months We may cover additional screenings if medically necessary.	$0
Diabetic self-management training, services, and supplies The plan will pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: – A blood glucose monitor – Blood glucose test strips – Lancet devices and lancets – Glucose-control solutions for checking the accuracy of test strips and monitors **This benefit is continued on the next page**	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Diabetic self-management training, services, and supplies (continued) • For people with diabetes who have severe diabetic foot disease, the plan will pay for the following: – One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or** – One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes. • The plan will pay for training to help you manage your diabetes, in some cases. We limit the brands and makers of diabetic supplies we will pay for. The supplies listed below are covered for UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) members without prior authorization: • We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, OneTouch® Verio, OneTouch®Ultra 2, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan. You can also find covered diabetic testing supplies in the **List of Covered Drugs** at **myuhc.com/communityplan**.	$0 *Your provider may need to obtain prior authorization*

Services that our plan pays for	What you must pay
Durable medical equipment (DME) and related supplies (For a definition of "Durable medical equipment (DME)," refer to Chapter 12 (Definitions of important words) as well as Chapter 3, Section M of this handbook.) Generally, UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) covers any DME covered by Medicare and Medical Assistance (Medicaid) from the brands and makers on this list. We will not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically right for you after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.) If you (or your doctor) do not agree with the plan's coverage decision, you or your doctor may file an appeal. You can also file an appeal if you do not agree with your doctor's decision about what product or brand is right for your medical condition. (For more information about appeals, refer to Chapter 9. The following items are covered: • Wheelchairs • Crutches • Walkers • Powered mattress systems • Hospital beds ordered by a provider for use in the home • IV infusion pumps • Speech generating devices • Oxygen equipment and supplies • Nebulizers **This benefit is continued on the next page**	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Durable medical equipment (DME) and related supplies (continued) We cover additional items, including: • repairs of medical equipment • batteries for medical equipment • medical supplies you need to take care of your illness, injury or disability • incontinence products • nutritional/enteral products when specific conditions are met • family planning supplies (refer to the "Family planning services" section of this chart for more information) • augmentative communication devices, including electronic tablets For diabetic supplies refer to the "Diabetic self-management training, services, and supplies" section in this benefit chart. We will pay for all medically necessary DME that Medicare and Medical Assistance (Medicaid) usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Elderly Waiver Services (Home and Community-Based Services) UnitedHealthcare uses the MN Department of Human Services (DHS) Open Network for Adult Day Services, Family Adult Day Services and Customized Living/24 Hour Customized Living Providers. Visit **https://mhcpproviderdirectory.dhs.state.mn.us/** Note: the DHS Open Network directory may not have all home and community-based providers listed. Visit **MinnesotaHelp.info** for more home and community-based services and waiver providers. You can call Member Services for more information, or your care coordinator can arrange these services for you. The plan will pay for the following services for individuals eligible to get Elderly Waiver (EW) services: • Adult Companion Services: Non-medical care, supervision and socialization. • Adult Day Services (ADS) and ADS Bath: Licensed program that delivers a set of health, social and nutritional services. ADS Bath is optional. Also includes FADS – Family Adult Day services. • Adult Foster Care: Licensed, adult appropriate, sheltered living arrangement in a family-like setting. • Case Management: Management of your health and long-term care services among different health and social service workers. • Chore Services: Heavy household services needed to keep your home clean and safe. • Consumer Directed Community Support Services: Services that you design to meet your needs and manage yourself within a set budget. **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Elderly Waiver Services (Home and Community-Based Services) (continued) • Customized Living/24-Hour Customized Living: A group of individualized services (health related and supported services) provided in a qualified setting. • Environmental Accessibility Adaptations: Physical changes to your home and vehicle needed to assure health and safety and enable you to be more independent. • Extended State Plan Home Health Care Services: This includes home health aide and nursing services that are over the Medical Assistance (Medicaid) limit. • Extended State Plan Home Care Nursing: This includes home care nursing services that are over the Medical Assistance (Medicaid) limit. • Extended State Plan Personal Care Assistance (PCA) Services (Community First Services and Supports (CFSS) replaces PCA services when the State of Minnesota gets Federal approval to provide this service): Help with personal care and activities of daily living (ADLs) over the Medical Assistance (Medicaid) limit. PCAs can also assist with instrumental activities of daily living (IALDs) • Family and Caregiver Services: Training, education, coaching and counseling for unpaid caregivers. This includes training and education, coaching and counseling with assessment and Family Memory Care. • Home Delivered Meals: An appropriate, nutritionally balanced meal delivered to your home. • Homemaker Services: General household activities to keep up the home. These range from general household cleaning to incidental assistance with home management and/or activities of daily living. **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Elderly Waiver Services (Home and Community-Based Services) (continued) • Individual Community Living Support Services: A bundled service to offer assistance and support to remain in your own home including reminders, cues, intermittent supervision or physical assistance. • Respite Care: Short-term service when you cannot care for yourself, and your unpaid caregiver needs relief. • Specialized Medical Supplies and Equipment: Supplies and equipment that are over the Medical Assistance (Medicaid) limit or coverage or are not a part of other Medical Assistance (Medicaid) coverage but are specified in your support plan. This includes the Personal Emergency Response System (PERS). • Transitional Supports Services: Items and supports necessary to move from a licensed setting to an independent or semi-independent community-based housing. • Transportation: Enables you to gain access to activities and services in the community. You must have a MnCHOICES assessment, formerly called a Long-Term Care Consultation (LTCC), done and be found to be nursing home certifiable to get these Elderly Waiver (EW) services. You can ask to have this assessment in your home, apartment, or facility where you live. Your MSHO care coordinator will meet with you and your family to talk about your care needs within 20 days if you call to ask for a visit. Your MSHO care coordinator will give you information about community services, help you find services to stay in your home or community, and help you find services to move out of a nursing home or other facility. **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Elderly Waiver Services (Home and Community-Based Services) (continued) You have the right to have friends or family present at the visit. You can designate a representative to help you make decisions. You can decide what your needs are and where you want to live. You can ask for services to best meet your needs. You can make the final decisions about your plan for services and help. You can choose who you want to provide the services and supports from those providers available from our plan's network. After the visit, your MSHO care coordinator will send you a letter that recommends services that best meet your needs. You will be sent a copy of the service or care plan you helped put together. Your MSHO care coordinator will help you file an appeal if you disagree with suggested services or were informed you may not qualify for these services. People who live on or near the White Earth, Leech Lake, Red Lake, Mille Lacs, or Fond du Lac Reservations may be able to choose to get their EW services through the Tribal health or human services division or through our plan. Contact the tribal nation or our plan if you have questions. If you are currently on the Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver, you will continue to get services covered by these programs in the same way you get them now. Your county case manager will continue to authorize these services and coordinate with your MSHO care coordinator. If you need transition planning and coordination services to help you move to the community, you may be eligible to get Moving Home Minnesota (MHM) services. MHM services are separate from EW services, but you must be eligible for EW.	$0

Services that our plan pays for	What you must pay
Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to treat a medical emergency. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your health; **or** • serious harm to bodily functions; **or** • serious dysfunction of any bodily organ or part This coverage is only available within the U.S. and its territories. If you receive 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 in order for your care to continue to be covered or you must have your inpatient care at the out-of- network hospital authorized by the plan. When outside of the United States and its territories, the plan covers emergency transportation to a nearby medical facility within the foreign country.	$0

Services that our plan pays for	What you must pay
Family planning services The law lets you choose any provider to get certain family planning services from. These are called open access services. This means any doctor, clinic, hospital, pharmacy, or family planning office. The plan will pay for the following services: • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods with prescription (for example, birth control pills) • Family planning supplies with prescription (for example, condoms) • Counseling and diagnosis of infertility, including related services • Counseling and testing for sexually transmitted diseases (STDs) • Counseling and testing for HIV/AIDS and other HIV-related conditions • Treatment for sexually transmitted diseases (STDs) • Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • Genetic counseling The plan will also pay for some other family planning services. However, you must refer to a provider in the plan's network for the following services: • Treatment for medical conditions of infertility • Treatment for AIDS and other HIV-related conditions • Genetic testing **Note:** Our plan does not cover artificial ways to become pregnant (artificial insemination, including in vitro fertilization and related services; fertility drugs and related services), reversal of voluntary sterilization, and sterilization of someone under conservatorship or guardianship.	$0

Services that our plan pays for	What you must pay
Fitness program: Renew Active® by UnitedHealthcare® Renew Active by UnitedHealthcare is the gold standard in Medicare fitness programs for body and mind. Renew Active includes: • A free gym membership, access to our nationwide network of gyms and fitness locations, a personalized fitness plan plus thousands of on-demand workout videos and live streaming fitness classes. • An online brain health program with exclusive content for Renew Active members from AARP® Staying Sharp. • Social activities at local health and wellness classes and events. • An online Fitbit® Community for Renew Active. No Fitbit device is needed. • 1 at-home fitness kit for members 15 miles or more from a participating fitness center. You can get more information by viewing the Vendor Information Sheet at **myuhc.com/communityplan** or by calling Member Services to have a paper copy sent to you.	$0

Services that our plan pays for	What you must pay
Health services The plan will pay for the following services: • Advanced Practice Nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist • Allergy immunotherapy and allergy testing • Behavioral Health Home: coordination of behavioral and physical health service • Clinical trial coverage – Routine care that is provided as part of the protocol treatment of a clinical trial; is usual, customary, and appropriate to your condition; and would typically be provided outside of a clinical trial. – This includes services and items needed for the treatment of effects and complications of the protocol treatment. – For more information, please refer to Chapter 3 (Using the plan's coverage for your health care and other covered services) • Community health worker care coordination and patient education services • Community Medical Emergency Technician (CMET) services – Post-hospital/post-nursing home discharge visits ordered by your primary care provider – Safety evaluation visits ordered by your primary care provider **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Health services (continued) • Community Paramedic: certain services provided by a community paramedic. The services must be a part of a care plan ordered by your primary care provider. The services may include: – Health assessments – Chronic disease monitoring and education – Help with medications – Immunizations and vaccinations – Collecting lab specimens – Follow-up care after being treated at a hospital – Other minor medical procedures • Hospital In-Reach Community-Based Service Coordination (IRSC): coordination of services targeted at reducing hospital emergency room (ER) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ER and other health care services. • Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit • Telemonitoring: use of special equipment to send health data to providers from a remote location, like a member's home. Providers use telemonitoring to help manage complex health care without the need for the member to be in a clinic or hospital. • Tuberculosis care management and direct observation of drug intake	$0

Services that our plan pays for	What you must pay
Hearing services The plan pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We cover additional items and services, including: • Hearing aids and batteries • Repair and replacement of hearing aids due to normal wear and tear, with limits	$0 Provided by: Plan network providers in your service area
Hearing Aids Through UnitedHealthcare Hearing, you can choose from a broad selection of name-brand hearing aids, or UnitedHealthcare Hearing's brand Relate™, custom-programmed for your hearing loss at the allowance level listed. Hearing aids can be fit in person with a network provider or delivered directly to you with virtual follow-up care through Right2You (select models). This benefit is limited to 2 hearing aids every year. Hearing aid accessories and optional services are available for members for purchase, but they are not covered by the plan. To access your hearing aid benefit and get connected with a network provider, you must contact UnitedHealthcare Hearing at **1-877-704-3384**, TTY **711** or visit **UHCHearing.com/SNP**. Hearing aids purchased outside of the UnitedHealthcare Hearing network are not covered.	Hearing aid allowance is $2,000.00 Includes hearing aids delivered directly to you with virtual follow-up care through Right2You (select models). *You must obtain prior authorization from UnitedHealthcare Hearing*.
HIV screening The plan pays for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. Additional benefits may be covered by us.	$0

Services that our plan pays for	What you must pay
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. The plan will pay for the following services, and maybe other services not listed here: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies • Respiratory therapy • Home Care Nursing (HCN) • Personal care assistant (PCA) services and supervision of PCA services (Community First Services and Supports (CFSS) replaces PCA services when the State of Minnesota gets Federal approval to provide this service.)	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Home infusion therapy The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; **and** • Supplies, such as tubing or a catheter. The plan will cover home infusion services that include but are not limited to: • Professional services, including nursing services, provided in accordance with your care plan; • Member training and education not already included in the DME benefit; • Remote monitoring; **and** • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	$0

Services that our plan pays for	What you must pay
Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find a hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider. The plan will pay for the following while you are getting hospice services: • Drugs to treat symptoms and pain • Short-term respite care • Home care **Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Refer to Section F of this chapter for more information. **For services covered by the plan but not covered by Medicare Part A or Medicare Part B:** • The plan will cover plan-covered services not covered under Medicare Part A or Medicare Part B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by the plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 (Getting your outpatient prescription drugs through the plan) **Note:** If you need non-hospice care, you should call your care coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.	$0

Services that our plan pays for	What you must pay
Housing stabilization services The plan will pay for the following services for members eligible for Housing Stabilization Services: • Housing consultation services to develop a person-centered plan for people without Medical Assistance case management services • Housing transition services to help you plan for, find, and move into housing • Housing sustaining services to help you maintain housing • Transportation to get housing stabilization services (within a 60 mile radius) You must have a Housing Stabilization Services eligibility assessment done and be found eligible for these services. If you need Housing Stabilization Services, you can ask for an assessment or be supported by your provider or case manager. If you have a targeted case manager or waiver case manager or senior care coordinator, that case manager can support you in accessing services, or you can contact a Housing Stabilization Services provider directly to help you. Department of Human Services (DHS) staff will use the results of the assessment to determine whether you meet the needs-based criteria to get this service. DHS will send you a letter of approval or denial for Housing Stabilization Services.	$0 *You may need to obtain prior authorization*

Services that our plan pays for	What you must pay
Immunizations The plan will pay for the following services: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules The plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 (What you pay for your Medicare and Medical Assistance (Medicaid) prescription drugs) to learn more.	$0

Services that our plan pays for	What you must pay
Inpatient hospital care The plan will pay for the following services, and maybe other services not listed here: • Semi-private room (or a private room if it is medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance use disorder services • Blood, including storage and administration – The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need. • Physician services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. For heart transplants this also includes a Ventricular Assist Device inserted as a bridge or as a destination therapy treatment. If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area.	$0 You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control. *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Inpatient services in a psychiatric hospital The plan will pay for mental health care services that require a hospital stay, including extended psychiatric inpatient hospital stays.	$0 *Your provider must obtain prior authorization*
Interpreter services The plan will pay for the following services: • Spoken language interpreter services • Sign language interpreter services	$0
Kidney disease services and supplies The plan will pay for the following services: • Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 (Using the plan's coverage for your health care and other covered services), or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply **Your Medicare Part B drug benefit pays for some drugs for dialysis.** For information, please refer to "Medicare Part B prescription drugs" in this chart.	$0 *Your provider may need to obtain prior authorization for some services*

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Services that our plan pays for	What you must pay
Lung cancer screening The plan will pay for lung cancer screening every 12 months if you meet all of the following: • Are aged 50-77, **and** • Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.	$0
Meal Benefit This benefit can be used immediately following an inpatient hospital or skilled nursing facility (SNF) stay if recommended by a provider. **Benefit guidelines** • Receive up to 28 home-delivered meals for up to 14 days • First meal delivery may take up to 72 hours after ordered • Some restrictions and limitations may apply	$0 Provided by: Mom's Meals® Prior authorization is required.

Services that our plan pays for	What you must pay
Medical Assistance (Medicaid) covered prescription drugs The plan will cover some Medical Assistance (Medicaid) covered drugs that are not covered by Medicare Part B and Medicare Part D. These include some over-the-counter products, some prescription cough and cold medicines and some vitamins. The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor shows us that: • the drug that is normally covered has caused a harmful reaction to you; **or** • there is a reason to believe the drug that is normally covered would cause a harmful reaction; **or** • the drug prescribed by your doctor is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered. If pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by our plan. If the pharmacy won't call your doctor, you can. You can also call Member Services at the number at the bottom of this page.	$0
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. The plan will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if your treatment is needed in the next calendar year. We may cover additional benefits if medically necessary.	$0

Services that our plan pays for	What you must pay
Medicare Diabetes Prevention Program (MDPP) The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0

Services that our plan pays for	What you must pay
Medicare Part B prescription drugs These drugs are covered under Medicare Part B. The plan will pay for the following drugs: • Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or Ambulatory Surgical Center (ASC) services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit, such as shingles or tetanus booster shots. Chapter 5 (Getting your outpatient prescription drugs through the plan) explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6 (What you pay for your Medicare and Medical Assistance (Medicaid) prescription drugs) explains what you pay for your outpatient prescription drugs through our plan.	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Mental health services Refer to the following sections for covered mental health services: • Depression screening • Inpatient mental health care • Outpatient mental health care • Partial hospitalization services	$0
NurseLine NurseLine services available, 24 hours a day, 7 days a week. Speak to a registered nurse (RN) about your medical concerns and questions. You can view the Vendor Information Sheet at **myuhc.com/communityplan** or call Member Services to have a paper copy sent to you.	$0 Provided by: NurseLine
Nursing facility care The plan is responsible for paying a total of 180 days of nursing home room and board. This includes custodial care. If you need continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for your care. If DHS is currently paying for your care in the nursing home, DHS, not the plan, will continue to pay for your care. Refer to the "Skilled nursing facility (SNF) care" section of this chart for more information about the additional nursing home coverage the plan provides.	$0
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, the plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more. We may cover additional benefits if medically necessary.	$0

Services that our plan pays for	What you must pay
Opioid treatment program (OTP) services The plan will pay for the following services to treat opioid use disorder (OUD): • Intake activities • Periodic assessments • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs, chemicals, or substances in your body (toxicology testing)	$0 *Your provider must obtain prior authorization*
Food, over-the-counter (OTC) and utility bill credit With this benefit, you'll get a credit loaded to your UnitedHealthcare UCard™ each month to pay for covered groceries, OTC items and certain utility bills. Unused credits expire at the end of each month. Covered items include: • Healthy foods like fruits, vegetables, meat, seafood, dairy products, water and more. • Brand name and generic OTC products, like vitamins, pain relievers, toothpaste, cough drops and more. • Eligible utility bills like electricity, gas, water and internet. The service address must match an address we have on file for you. The credit cannot be used to buy tobacco or alcohol. You can use your credit at thousands of participating stores or place an order online or over the phone through your catalog. Get free home delivery when you spend $35 or more. To receive a paper catalog, call Member Services or the number on the Vendor Information Sheet. You can also use your credit to pay eligible utility bills online, over the phone or at your local Walmart MoneyCenter or Customer Service Desk. Visit the UCard Hub at **myuhc.com/CommunityPlan** to find participating stores, check your balance, place an order online or pay utility bills.	$0 copayment Provided by: Solutran Monthly credit is $170

Services that our plan pays for	What you must pay
Outpatient diagnostic tests and therapeutic services and supplies The plan will pay for the following services, and maybe other services not listed here: • X-rays • Radiation (radium and isotope) therapy, including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used for fractures and dislocations • Lab tests • Blood, beginning with the first pint of blood that you need. The plan will pay for storage and administration beginning with the first pint of blood you need. • Other outpatient diagnostic tests	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Outpatient hospital services The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. The plan will pay for the following services, and maybe other services not listed here: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services – Observation services help your doctor know if you need to be admitted to the hospital as an "inpatient." – Sometimes you can be in the hospital overnight and still be an "outpatient." – You can get more information about being an inpatient or an outpatient in this fact sheet: **medicare.gov/media/11101** • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself	*$0* *Your provider may need to obtain prior authorization*

Services that our plan pays for	What you must pay
Outpatient mental health care The plan will pay for mental health services provided by any of the following: • a psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a nurse practitioner • a physician assistant • a Tribal certified professional • a mental health rehabilitative professional • a Licensed Professional Clinical Counselor (LPCC) • a licensed marriage and family therapist • any other Medicare-qualified mental health care professional as allowed under applicable state laws The plan will pay for the following services, and maybe other services not listed here: • Certified Community Behavioral Health Clinic (CCBHC) • Clinical care consultation • Crisis response services including screening, assessment, intervention, stabilization (including residential stabilization), and community intervention • Diagnostic assessments including screening for presence of co-occurring mental illness and substance use disorders **This benefit is continued on the next page**	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Outpatient mental health care (continued) • Dialectical Behavioral Therapy (DBT) • Intensive Outpatient Program (IOP) • Mental health provider travel time • Mental Health Targeted Case Management (MH-TCM) • Forensic Assertive Community Treatment (FACT) • Outpatient mental health services, including explanation of findings, mental health medication management, neuropsychological services, psychotherapy (patient and/or family, family, crisis and group), and psychological testing • Physician Mental Health Services, including health and behavioral assessment/intervention, inpatient visits, psychiatric consultations to primary care providers, and physician consultation, evaluation, and management • Rehabilitative Mental Health Services, including Assertive Community Treatment (ACT), Adult day treatment, Adult Rehabilitative Mental Health Services (ARMHS), Certified Peer Specialist (CPS) support services in limited situations, Intensive Residential Treatment Services (IRTS), and Partial Hospitalization Program (PHP) • Telemedicine If we decide no structured mental health treatment is necessary, you may get a second opinion. For the second opinion, we must allow you to use any qualified health professional that is not in the plan network. We will pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision. We will not determine medical necessity for court-ordered mental health services. Use a plan network provider for your court-ordered mental health assessment.	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Outpatient rehabilitation services The plan will pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0 *Your provider must obtain prior authorization*
Outpatient surgery The plan will pay for outpatient surgery and services at hospital outpatient facilities and Ambulatory Surgical Centers (ASCs).	$0 *Your provider must obtain prior authorization*
Partial hospitalization services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.	$0 *Your provider must obtain prior authorization*
Personal Emergency Response System With a Personal Emergency Response System (PERS), help is only a button press away. A PERS device can quickly connect you to the help you need, 24 hours a day in any situation. It's a lightweight, discreet button that can be worn on your wrist or as a pendant. It's also safe to wear in the shower or bath. Depending on the model you choose, it may even automatically detect falls. You must have a working landline or live in an area that has AT&T wireless coverage to get a PERS device. The cellular device works nationwide with the AT&T wireless network, but does not require you to have AT&T coverage. You can view the Vendor Information Sheet at **myuhc.com/communityplan** or call Member Services to have a paper copy sent to you.	$0 Provided by: Lifeline

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

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: – you're not a new patient **and** – the check-in isn't related to an office visit in the past 7 days **and** – the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if: – you're not a new patient **and** – the evaluation isn't related to an office visit in the past 7 days **and** – the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion before surgery • Non-routine dental care. Covered services are limited to: – surgery of the jaw or related structures, – setting fractures of the jaw or facial bones, – pulling teeth before radiation treatments of neoplastic cancer, **or** – services that would be covered when provided by a physician. • For information about other dental services we cover, refer to the "Dental services" section of this chart. • Preventive and physical exams • Family Planning services. For more information, refer to the "Family planning" section of this chart. **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) • Certain telehealth services, including: – Additional Virtual Medical Visits: • Urgently Needed Services • Primary Care Provider • Specialist • Other Health Care Professionals – Other types of Virtual Medical Visits: • Cardiac Rehabilitation Services • Intensive Cardiac Rehabilitation Services • Outpatient Rehabilitation Services • Occupational Therapy • Physical Therapy and Speech-Language Therapy – Additional Mental Health telehealth visits: • Covered services include individual mental health services • Virtual Mental Health Visits are mental health visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/video capabilities. Visit virtualvisitsmentalhealth.uhc.com to learn more and schedule a virtual appointment. – You have the option of receiving getting these services either through an in-person visit or via by telehealth. If you choose to receive get one of these services via by telehealth, then you must use a network provider that currently who offers the service via by telehealth. • Virtual Medical Visits are medical visits delivered to you outside of medical facilities by network providers that have appropriate online technology and live audio/video capabilities to conduct the visit. • 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.	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Podiatry services The plan will pay for the following services: • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members when medically necessary including conditions affecting the legs, such as diabetes • Other non-routine foot care such as debridement of toenails and infected corns and calluses • Routine foot care visit once every 60 days that includes cutting or removal of corns and calluses, trimming, cutting, clipping, or debriding of nails. Coverage is based on diagnosis. 6 routine foot care visits are covered every year by Medicare.	$0 *Authorization is required for Medicare-covered podiatry. Routine foot care visits do not require authorization.*
Prostate cancer screening exams For men, the plan will pay for the following services once every 12 months: • A digital rectal exam • A prostate specific antigen (PSA) test	$0

Services that our plan pays for	What you must pay
Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. The plan will pay for the following prosthetic devices, and maybe other devices not listed here: • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Orthotics • Wigs for people with alopecia areata • Some shoes when a part of a leg brace or when custom molded. The plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this section for details.	$0 *Your provider must obtain prior authorization*
Pulmonary rehabilitation services The plan will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Routine transportation Details of this benefit: • UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) offers 48 one-way trips to or from approved locations which are covered each year (limited to ground transportation only) in addition to what is covered under Medical Assistance (Medicaid). • We will not limit transportation trips to medical appointments and pharmacies under Medical Assistance (Medicaid). • You are responsible for any costs over the trip limit. • Trips must be to or from plan-approved locations, such as network providers, medical facilities, pharmacies, gyms, or hearing and vision appointments. • Each one-way trip must not exceed 60 miles of driving distance. A trip is one-way transportation; a round trip is 2 trips. • Transportation services must be requested 3 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 or door-to-door service. • Wheelchair vans may be available upon request. • Drivers do not have medical training. In case of emergency, call **911**. Under Medicare, this benefit does not cover transportation by: • Stretcher • Ambulance; you may be able to qualify for these modes under Medical Assistance (Medicaid). You can get more information on non-emergent medical transportation by calling Member Services at **1-844-368-5888**.	$0

Services that our plan pays for	What you must pay
Sanvello Self-help mobile digital application that focuses on empowering individuals in improving their mental health, through interaction with their smart phone application tools and activities.	$0

Services that our plan pays for	What you must pay
Second Harvest Heartland FOODRx program As part of our efforts to connect the full resources of our community with our food insecure enrollees, we will partner with Second Harvest Heartland to provide a food prescription program for subset of members with chronic conditions and/or those who recently experienced an inpatient stay. Core components of the program include tools for a healthy lifestyle change with clinically tailored and culturally specific meals, a local engagement coordinator for proactive monthly outreach to members, and tracking and evaluation of program metrics related to member outreach, enrollment and persistence within the program. Particularly for the seniors population, the programs' member outreach component serves to mediate social isolation and loneliness, providing an opportunity for members to regularly connect with trained Second Harvest staff. The FOODRx program also includes SNAP referral and assistance, ensuring members will have access to healthy foods after the six-month programs end. Although Second Harvest is based in the Metro area, we have partnered with them and their delivery vendor to provide this benefit statewide. • FOODRx Chronic Disease Box with Produce Add-on: Members with diabetes and other chronic conditions participating in this program will receive 25 culturally tailored meals provided monthly and delivered to their doorstep (no transportation barrier to receiving food) for six months. In each box, enrollees receive education materials related to living with chronic disease and recipes to assist with selecting and preparing healthy food. FOODRx boxes are available in two culturally tailored cuisines, American and Hispanic, with a third vegetarian option for those whose cultural, religious, or personal dietary practices call for it. Enrollees can choose different cuisines each month (e.g., vegetarian the first month, Hispanic the second month and so on). In addition, to supplement the shelf-stable food provided in the FOODRx box, enrollees will receive a separate box of fresh, local produce each month for the six-month program. This additional box of produce not only allows members to cook more nutritionally-balanced meals, but also allows them to make culturally-aligned meals that require fresh fruits and vegetables. State eligibility requirements may apply.	$0

Services that our plan pays for	What you must pay
Seeking Safety Seeking Safety is a manual based model that helps individuals dealing with trauma/PTSD and substance abuse establish safety in their lives. Seeking Safety applies 25 coping skills to help attain and maintain safety in relationships, thinking, behaviors and emotions.	$0
Sexually transmitted diseases (STDs) screening and counseling The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. A primary care provider must order the tests. We cover these tests once every 12 months. The plan will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STDs. Each session can be 20 to 30 minutes long. The plan will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0
Skilled nursing facility (SNF) care For additional nursing home services covered by us, refer to the "Nursing facility care" section. You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. **This benefit is continued on the next page**	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Skilled nursing facility (SNF) care (continued) The plan will pay for the following services, and maybe other services not listed here: • A semi-private room, or a private room if it is medically necessary • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • Blood, including storage and administration – The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need. • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services A 3-day prior hospital stay is not required. You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • A nursing facility where your spouse or domestic partner lives at the time you leave the hospital	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Smoking and tobacco use cessation If you use tobacco but do not have signs or symptoms of tobacco-related disease: • The plan will pay for two attempts to quit with counseling in a 12-month period as a preventive service. • This service is free for you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • The plan will pay for two attempts to quit with counseling within a 12-month period. Each counseling attempt includes up to four face-to-face visits. We may cover additional benefits if medically necessary.	$0
Substance use disorder services The plan pays for the following services: • Screening/assessment/diagnosis • Outpatient treatment • Inpatient hospital • Residential non-hospital treatment • Outpatient methadone treatment • Substance use disorder treatment coordination • Peer recovery support • Detoxification (only when inpatient hospitalization is medically necessary because of conditions resulting from injury or medical complications during detoxification) • Withdrawal management **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Substance use disorder services (continued) A qualified assessor who is a part of our plan's network will decide what type of substance use disorder care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor We will do this within five working days of when we get your request. If you agree with the second assessment, you may access services according to substance use disorder standards and the second assessment. You have the right to appeal. Refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).	$0
Supervised exercise therapy (SET) The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for: • Up to 36 sessions during a 12-week period if all SET requirements are met • An additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • In a hospital outpatient setting or in a physician's office • Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0

Services that our plan pays for	What you must pay
Traditional Healing Traditional healing used in or for traditional medicine or ceremonial purposes for American Indian members. Up to $250 per calendar year. Eligibility requirements may apply.	$0
Transportation If you need transportation to and from health services that we cover, call **1-888-444-1519** to schedule your ride. We will provide the most appropriate and cost-effective mode of transportation. Our plan is not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home or if you choose a specialty provider that is more than 60 miles from your home. Available non-emergent transportation may include: • Non-emergency ambulance • Volunteer driver transport • Unassisted transport (taxi or public transportation) • Assisted transportation • Lift-equipped/ramp transport • Protected transportation • Stretcher transport **Note:** Our plan does not cover mileage reimbursement (for example, when you use your own car), meals, lodging, and parking, also including out of state travel. These services are not covered under the plan but may be available through the local county or tribal agency. Call your local county or tribal agency for more information.	$0

Services that our plan pays for	What you must pay
Urgently needed care Urgently needed care is care given to treat: • a non-emergency, **or** • a sudden medical illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider (for example, when you are outside the plan's service area or during the weekend).	$0
Virtual Mental Health Visits Virtual Mental Health Visits are mental health visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/video capabilities. Visit **virtualvisitsmentalhealth.uhc.com** to learn more and schedule a virtual appointment. Covered services include individual mental health services. Not all conditions can be treated through virtual visits. The virtual visit provider will identify if you need to see an in-person provider for treatment.	$0

Services that our plan pays for	What you must pay
Vision care The plan will pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. For people at high risk of glaucoma, the plan will pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma, • people with diabetes, • African-Americans, **and** • Hispanic Americans. The plan will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Vision care (continued) We also cover the following: • Eye exams • Initial eyeglasses, when medically necessary. Selection may be limited. • Replacement eyeglasses, when medically necessary. Identical replacement of covered eyeglasses for loss, theft, or damage beyond repair. • Repairs to frames and lenses for eyeglasses covered under the plan • Tinted, photochromatic (such as Transitions®) lenses, or polarized lenses, when medically necessary • Contact lenses, when medically necessary under certain circumstances **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Vision care (continued) **Routine Eye Exam** • 1 routine eye exam (eye refraction) each year • If you belong to a medical group or IPA, you may have to receive these services through them. Please contact Member Services for more information. **Routine Eyewear** • Standard lenses and frames are covered as needed when medically necessary. Standard lenses that are covered in full include single vision, lined bifocal, lined trifocal, lenticular, and Tier I (standard) progressive lenses. or • Contact lenses instead of lenses and frames are covered as needed when medically necessary. Once contact lenses are selected and fitted, they may be exchanged for eyeglasses when medically necessary. Options that are not covered include (but are not limited to) non-prescription eyewear, upgraded progressive lenses, blended bifocal, Hi Index, tinting, scratch coating, UV or anti-reflective coating, and polycarbonate. This benefit may not be combined with any in-store promotional offer, such as a 2-for-1 sale, discount, or coupon. You can get more information by viewing the Vendor Information Sheet at **myuhc.com/communityplan** or by calling Member Services to have a paper copy sent to you.	$0 Covered as needed when medically necessary. Contact lenses are covered as needed in lieu of eyeglasses when medically necessary. *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0
White Bison White Bison offers sobriety, recovery, addiction prevention, and wellness/Wellbriety learning resources to the Native American/Alaska Native community nationwide. Eligibility requirements apply.	$0

Section E Benefits covered outside of UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP)

The following services are not covered by UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) but are available through Medicare.

Section E1 Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) pays for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis:

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

For drugs that may be covered by UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP)'s Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 (Getting your outpatient prescription drugs through the plan).

Note: If you need non-hospice care, you should call your care coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis.

Section E2 Other Services

The following services are not covered by us under the plan but may be available through another source, such as the state, county, federal government, or tribe. To find out more about these

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

services, call the Minnesota Health Care Programs Member Helpdesk at **651-431-2670** or **1-800-657-3739** (toll-free). TTY users should call **1-800-627-3529**.

- Case management for people with developmental disabilities
- Intermediate care facility for people who have a developmental disability (ICF/DD)
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Services provided by a state regional treatment center or a state-owned long-term care facility unless approved by us or the service is ordered by a court under conditions specified in law
- Services provided by federal institutions
- Except Elderly Waiver services, other waiver services provided under Home and Community-Based Services waivers
- Job training and educational services
- Day training and habilitation
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Nursing home stays for which our plan is not otherwise responsible. (Refer to the "Nursing facility care" and the "Skilled nursing facility (SNF) care" sections in the Benefits Chart for additional information.)
- Room and board for substance use disorder treatment as determined necessary by substance use disorder assessment
- Medical Assistance (Medicaid) covered services provided by Federally Qualified Health Centers (FQHCs)

Section F Benefits not covered by UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP), Medicare, or Medical Assistance (Medicaid)

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not pay for these benefits. Medicare and Medical Assistance (Medicaid) will not pay for them either.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this **Member Handbook**) except under the specific conditions listed. Even if you receive the

services at an emergency facility, the plan will not pay for the services. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medical Assistance (Medicaid), unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Refer to Chapter 3 (Using the plan's coverage for your health care and other covered services) for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically necessary and Medicare and/or Medical Assistance (Medicaid) pays for it.
- A private room in a hospital, except when it is medically necessary.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Fees charged by your immediate relatives or members of your household. Exceptions to this may be for some services, such as personal care assistance (PCA) and consumer-directed community supports (CDCS) services.
- Elective or voluntary enhancement procedures or services (including hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Routine foot care, except for the limited coverage listed in the Benefits Chart.
- LASIK surgery.
- Reversal of sterilization procedures.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Chapter 5

Getting your outpatient prescription drugs through the plan

Introduction

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

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) also covers the following drugs, although they will not be discussed in this chapter:

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

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
2. Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
3. Your prescriber must either accept Medicare or file documentation with CMS showing that they are qualified to write prescriptions. You should ask your prescribers the next time you call or visit if they meet this condition.
4. You generally must use a network pharmacy to fill your prescription.
5. Your prescribed drug must be on the plan's **List of Covered Drugs**. We call it the "Drug List" for short.
   - If it is not on the Drug List, we may be able to cover it by giving you an exception.
   - Refer to Section D, "Reasons your drug might not be covered," to learn about asking for an exception.

6. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical references.

Table of Contents

Section A Getting your prescriptions filled

Section A1 Filling your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions only if they are filled at the plan's network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, you can look in the **Provider and Pharmacy Directory**, visit our website, or contact Member Services at the number at the bottom of this page or your care coordinator.

You can get a print copy of the **Provider and Pharmacy Directory** by calling Member Services at the number at the bottom of this page.

At any time, you can get up-to-date information about changes in the pharmacy network on our website at **myuhc.com/communityplan**.

Section A2 Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to 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 pay you back. If you cannot pay for the drug, contact Member Services right away. We will do what we can to help.

- To learn how to ask us to pay you back, refer to Chapter 7 (Asking us to pay a bill you have gotten for covered services or drugs).
- **NOTE:** If the drug is covered by Medical Assistance (Medicaid), we do not allow UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) providers to bill you for these drugs. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges. If you paid for a drug that you think we should have covered, contact Member Services at the number at the bottom of this page.
- If you need help getting a prescription filled, you can contact Member Services at the number at the bottom of this page or your care coordinator.

Section A3 What to do if you change to a different network pharmacy

If you need help changing your network pharmacy, you can contact Member Services or your care coordinator.

Section A4 What to do if your pharmacy leaves the network

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

To find a new network pharmacy, you can look in the **Provider and Pharmacy Directory**, visit our website, or contact Member Services or your care coordinator.

Section A5 Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home.
  - Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy is not in our network, or you have any difficulty accessing your drug benefits in a long-term care facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, you can look in the **Provider and Pharmacy Directory**, visit our website, or contact Member Services or your care coordinator.

Section A6 Using mail-order services to get your drugs

Our plan's mail-order service allows you to order up to a 30-day supply.

Filling my prescriptions by mail

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

Usually, a mail-order prescription will get to you within 10 business days. However, sometimes your mail-order may be delayed. If your mail-order is delayed, please follow these steps:

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

Mail-order processes

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

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

   The pharmacy will automatically fill and deliver new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets directly from your provider'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 you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by phone or mail.

   If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please 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 find out if you want the medication filled and shipped immediately.

   - This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before it is shipped.
   - It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

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

   For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will 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 need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
   - If you choose not to use our auto refill program, please contact your pharmacy 10 days before your current prescription will run out to make sure your next order is shipped to you in time.

   To opt out of our program that automatically prepares mail-order refills, please contact the mail order pharmacy.

   So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Ask the pharmacy how they want to know your preference.

Section A7 Getting a long-term supply of drugs

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

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 100-day supply has the same copay as a one-month supply. To find which pharmacies can give you a long-term supply of maintenance drugs, you can look in the **Provider and Pharmacy Directory**, visit our website, or contact Member Services at the number at the bottom of the page or your care coordinator.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to the section above (Using mail-order services to get your drugs) to learn about mail-order services.

Section A8 Using a pharmacy that is not in the plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

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

- **Prescriptions for a medical emergency**
  We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Formulary without restrictions, and are not excluded from Medicare Part D coverage.
- **Coverage when traveling or out of the service area**
  If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network preferred mail service pharmacy or through our other network pharmacies. Contact Member Services to find out about ordering your prescription drugs ahead of time.
- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy is not within reasonable driving distance that provides 24-hour service.
- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- If you need a prescription while a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.

In these cases, please check first with Member Services to find out if there is a network pharmacy nearby.

Section A9 Paying you back if you pay for a prescription

If you must use an out-of-network pharmacy, you will generally have to pay the full cost when you get your prescription. You can ask us to pay you back.

To learn more about this, refer to Chapter 7 (Asking us to pay a bill you have gotten for covered services or drugs).

NOTE: If the drug is covered by Medical Assistance (Medicaid), we do not allow UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) providers to bill you for these drugs. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges. If you paid for a drug that you think we should have covered, contact Member Services at the number at the bottom of this page.

Section B The plan's Drug List

The plan has a **List of Covered Drugs**. We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

Section B1 Drugs on the Drug List

The Drug List includes the drugs covered under Medicare Part D and those covered under Medical Assistance (Medicaid).

The Drug List includes brand name drugs and generic drugs.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the Drug List, when we refer to "drugs," this could mean a drug or a biological product such as vaccines or insulin.

Generic drugs have the same active ingredients as brand name drugs. Generally, generics work just as well as brand name drugs and usually cost less. There are generic drug substitutes available for many brand name drugs.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services at the number at the bottom of this page.

Section B2 How to find a drug on the Drug List

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List.
- Visit the plan's website at **myuhc.com/communityplan**. The Drug List on the website is always the most current one.
- Call Member Services at the number at the bottom of this page to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

Section B3 Drugs that are not on the Drug List

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) will not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and Medicaid drugs) cannot pay for a drug that would be covered under Medicare Part A or Medicare Part B. Refer to the introduction of this chapter for more information about Medicare Part A and Medicare Part B covered drugs. Drugs covered under Medicare Part A or Medicare Part B are covered by UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration or supported by certain medical references as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medical Assistance (Medicaid).

- Drugs used to promote fertility.
- Drugs used for cosmetic purposes or to promote hair growth.
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®.
- Outpatient drugs when the company who makes the drugs says that you have to have tests or services done only by them.

Section B4 Drug List tiers

Every drug on our plan's Drug List is in a cost-sharing tier level. What you pay for a drug on the Drug List depends on whether the drug is a generic or brand name drug. Tier 1 generic drugs have the lowest copay. Tier 1 brand name drugs have a higher copay. Over-the-counter drugs and products have a $0 copay.

To find out the cost-sharing for your drug, look for the drug in our plan's Drug List.

Chapter 6 (What you pay for your Medicare and Medical Assistance (Medicaid) prescription drugs) tells the amount you pay for drugs in each tier.

Section C Limits on some drugs

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

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

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

   Generally, a generic drug works the same as a brand name drug and usually costs less. In most cases, if there is a generic version of a brand name drug, our network pharmacies will give you the generic version.

   • We usually will not pay for the brand name drug when there is a generic version.

   • However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand name drug.

2. **Getting plan approval in advance**

   For some drugs, you or your health care provider must get approval from UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) before you fill your prescription. If you don't get approval, UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) may not cover the drug. This is called prior authorization

3. **Trying a different drug first**

   In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first.

   If Drug A does not work for you, the plan will then cover Drug B. This is called step therapy.

4. **Quantity limits**

   For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services at the number at the bottom of this page or check our website at **myuhc.com/communityplan**.

Section D Reasons your drug might not be covered

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

- The drug you want to take is not covered by the plan. The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- The drug is covered, but there are special rules or limits on coverage for that drug. As explained in the section above (Limits on some drugs), some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

Section D1 Getting a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

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

1. The drug you have been taking:
   - is no longer on the plan's Drug List, **or**
   - was never on the plan's Drug List, **or**

- is now limited in some way.

2. You must be in one of these situations:
   - You are new to the plan.
     - We will cover a temporary supply of your **drug during the first 90 days of your membership in the plan.**
     - This temporary supply will be for up to 30 days.
     - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
   - You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.
     - We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
     - To ask for a temporary supply of a drug, call Member Services.

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

- You can change to another drug.

  There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

OR

- You can ask for an exception.

  You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

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

- We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year.
- We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

To learn more about asking for an exception, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

If you need help asking for an exception, you can contact Member Services or your care coordinator.

Section E Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior approval for a drug. (Prior approval is permission from UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless:

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

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

- Check UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP)'s up to date Drug List online at **myuhc.com/communityplan or**
- Call Member Services to check the current Drug List at **1-844-368-5888**.

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

- **A new generic drug becomes available.** Sometimes, a new generic drug comes on the market that works as well as a brand name drug on the Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

  – We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.

- You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9 of this handbook for more information on exceptions.

- **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. Your prescriber will also know about this change and can work with you to find another drug for your condition.

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

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will:

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

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

- If there is a similar drug on the Drug List you can take instead **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

We may make changes to drugs you take that do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change will not affect your use of the drug for the rest of the year.

Section F Drug coverage in special cases

Section F1 If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a copay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section F2 If you are in a long-term care facility

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

To find out if your long-term care facility's pharmacy is part of our network, you can look in the **Provider and Pharmacy Directory**, visit our website, or contact Member Services at the number at the bottom of the page or your care coordinator. If it is not, or if you need more information, please contact Member Services.

Section F3 If you are in a Medicare-certified hospice program

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

- If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal prognosis 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 any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. Refer to the previous parts of this chapter that tell about the rules for getting drug coverage under Medicare Part D.

To learn more about the hospice benefit, refer to Chapter 4 (Benefits Chart).

Section G Programs on drug safety and managing drugs

Section G1 Programs to help members use drugs safely

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

- May not be needed because you are taking another drug that does the same thing.
- May not be safe for your age or gender.
- Could harm you if you take them at the same time.
- Have ingredients that you are or may be allergic to.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- Have unsafe amounts of opioid pain medications.

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

Section G2 Programs to help members manage their drugs

If you take medications for different medical conditions and/or are in a Drug Management Program to help you use your opioid medications safely, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

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

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members who qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

If you have any questions about these programs, please contact Member Services or your care coordinator.

Section G3 Drug management program to help members safely use their opioid medications

UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from a certain pharmacy** and/or **from a certain doctor**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will explain the limitations we think should apply.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

The DMP may not apply to you if you:

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

Chapter 6

What you pay for your Medicare and Medical Assistance (Medicaid) prescription drugs

Introduction

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

Medicare Part D prescription drugs, **and**

- drugs and items covered under Medical Assistance (Medicaid), **and**
- drugs and items covered by the plan as additional benefits.

Because you are eligible for Medical Assistance (Medicaid), you are getting "Extra Help" from Medicare to help pay for your Medicare Part D prescription drugs.

Extra Help is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

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

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

- The plan's **List of Covered Drugs**.
  - We call this the "Drug List." It tells you:
    - Which drugs the plan pays for
    - Which cost-sharing tier level each drug is in
    - Whether there are any limits on the drugs
  - You can get a copy of the Drug List by calling Member Services at the number at the bottom of this page. You can also find the Drug List on our website at **myuhc.com/communityplan**. The Drug List on the website is always the most current.
- Chapter 5 of this **Member Handbook**.
  - Chapter 5 (Getting your outpatient prescription drugs through the plan) tells how to get your outpatient prescription drugs through the plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs are not covered by our plan.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- The plan's **Provider and Pharmacy Directory**.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan.
  - The **Provider and Pharmacy Directory** has a list of network pharmacies. You can read more about network pharmacies in Chapter 5 (Getting your outpatient prescription drugs through the plan).

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Section A The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you or others on your behalf pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you or others on your behalf pay for your prescriptions, plus the amount the plan pays.

When you get prescription drugs through the plan, we send you a summary called the **Explanation of Benefits**. We call it the EOB for short. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month.** The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made since January 1.
- **Drug price information.** This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives.** When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs will not count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to the Drug List. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under Medical Assistance (Medicaid). These drugs are included in the Drug List.

Section B How to keep track of your drug costs

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

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

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

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

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

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

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

To learn how to ask us to pay you back for the drug, refer to Chapter 7 (Asking us to pay a bill you have gotten for covered services or drugs).

NOTE: If the drug is covered by Medical Assistance (Medicaid), we do not allow UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) providers to bill you for these drugs. We pay our providers directly, and we protect you from any charges. If you paid for a drug that you think we should have covered, contact Member Services at the number at the bottom of this page.

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

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

4. **Check the EOBs we send you.**

   When you get an EOB in the mail, please make sure it is complete and correct. If you think something is wrong or missing or if you have any questions, please call Member Services at the number at the bottom of this page. Be sure to keep these EOBs. They are an important record of your drug expenses.

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

With UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP), you pay nothing for covered drugs as long as you follow the plan's rules.

Section C1 The plan's cost-sharing tiers

Cost-sharing tier levels are groups of drugs with the same copay. To find the cost-sharing tier level for your drugs, you can look in the Drug List.

- Tier 1 Generic drugs have the lowest copay. The copay is from $0 to $4.15, depending on your income and level of Medical Assistance (Medicaid) eligibility.
- Tier 1 Brand name drugs have a higher copay. The copay is from $0 to $10.35, depending on your income and level of Medical Assistance (Medicaid) eligibility.
- OTCs have a $0 copay.

Section C2 Your pharmacy choices

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

- a network pharmacy, **or**
- an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to Chapter 5 (Getting your outpatient prescription drugs through the plan) to find out when we will do that.

To learn more about these pharmacy choices, refer to Chapter 5 (Getting your outpatient prescription drugs through the plan) in this handbook and the plan's **Provider and Pharmacy Directory**.

Section C3 Getting a long-term supply of a drug

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

For details on where and how to get a long-term supply of a drug, refer to Chapter 5 (Getting your outpatient prescription drugs through the plan) or the **Provider and Pharmacy Directory**.

Section C4 What you pay

You can contact Member Services at the number at the bottom of this page, to find out how much your copay is for any covered drug.

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

Tier	A network pharmacy A one-month or up to a 100-day supply	The plan's mail-order service A one-month or up to a 100-day supply	A network long-term care pharmacy Up to a 31-day supply	An out-of-network pharmacy Up to a 30-day supply. Coverage is limited to certain cases. Refer to Chapter 5 (Getting your outpatient prescription drugs through the plan) for details.
Cost-Sharing **Tier 1 – Generic** (A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug)	$0	$0	$0	$0

Tier	**A network pharmacy** A one-month or up to a 100-day supply	**The plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to Chapter 5 (Getting your outpatient prescription drugs through the plan) for details.
Cost-Sharing **Tier 1 – Brand name** (A prescription drug that is made and sold by the company that originally made the drug)	$0	$0	$0	$0
Cost-Sharing **Over-the-counter drugs and products** (any drug or medicine that a person can buy without a prescription from a health care professional)	$0	$0	$0	$0

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

Section D Vaccinations

Important Message About What You Pay for Vaccines – Our plan covers most Medicare Part D vaccines at no cost to you. There are two parts to our coverage of Medicare Part D vaccinations:

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

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

We recommend that you call us first at Member Services at the number at the bottom of this page whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan.

Chapter 7

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

Introduction

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

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Section A Asking us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for the services and drugs you already got. A network provider is a provider who works with the health plan.

We do not allow UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care services or drugs, send the bill to us. You should not pay the bill yourself. To send us a bill, refer to Section B of this chapter (Sending a request for payment).

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are **not** covered, we will tell you.
- Remember, if you get a bill from a provider, you should not pay the bill yourself.

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

  Here are examples of times when you may need to ask our plan to pay a bill you got or to pay you back:

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

   You should ask the provider to bill the plan.

   - You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill.
   - If the provider should be paid, we will pay the provider directly.

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

   Network providers must always bill the plan. Show your UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than your share of the cost for services. **Call Member Services at the number at the bottom of this page if you get any bills.**

   - Because UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
   - Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.

3. **When you use an out-of-network pharmacy to get a prescription filled**

If you use an out-of-network pharmacy, you will have to pay the full cost of your Medicare Part D prescription.

- In only a few cases, we will cover Medicare Part D prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Please refer to Chapter 5 (Getting your outpatient prescription drugs through the plan) to learn more about out-of-network pharmacies.

4. **When you pay the full cost for a Medicare Part D prescription because you do not have your Member ID Card with you**

   If you do not have your Member ID Card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information.

   - If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the Medicare Part D prescription yourself.
   - Send us a copy of your receipt when you ask us to pay you back.

5. **When you pay the full cost for a Medicare Part D prescription drug that is not covered**

   You may pay the full cost of the Medicare Part D prescription because the drug is not covered.

   - The drug may not be on the plan's **List of Covered Drugs** (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
     - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
     - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
   - Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for the drug.

When you send us a request for payment, we will review your request and decide whether the drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for the drug. If we deny your request for payment, you can appeal our decision.

To learn how to make an appeal, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

Section B Sending a request for payment

We do not allow UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) providers to bill you for services or drugs. We pay our providers directly, and we protect you from any charges.

You should not pay the bill yourself. Send us the bill. You can also ask your care coordinator for help.

To make sure you are 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 do not have to use the form, but it will help us process the information faster.
- You can get a copy of the form on our website (**myuhc.com/communityplan**), or you can call Member Services and ask for the form.

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

UnitedHealthcare
P.O. Box 5270
Kingston, NY 12402-5270

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

Section C Coverage decisions

When we get your request for payment, we will make a coverage decision. This means that we will decide whether your health care or drug is covered by the plan.

We do not allow UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) providers to bill you for covered services or drugs. We pay our providers directly, and we protect you from any charges.

We will let you know if we need more information from you.

Chapter 3 (Using the plan's coverage for your health care and other covered) explains the rules for getting your service covered.

Chapter 5 (Getting your outpatient prescription drugs through the plan) explains the rules for getting your Medicare Part D prescription drugs covered.

Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) explains how to learn more about coverage decisions.

Section D Appeals

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

The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

- If you want to make an appeal about a health care service, refer to Section E (Problems about services, items, and drugs (not Medicare Part D drugs)).
- If you want to make an appeal about a Medicare Part D drug, refer to Section F (Medicare Part D drugs).

Chapter 8

Your rights and responsibilities

Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook.**

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If you have questions, please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

We must ensure that **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about the plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. To make or change a standing request to get this document, now and in the future, in a language other than English or in an alternate format, call Member Services at the number at the bottom of this page.

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

- Medicare at **1-800-MEDICARE (1-800-633-4227)**. You can call 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- Member Services at **1-844-368-5888**, TTY **711** (or your preferred relay service), 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free.
- Office of Civil Rights at **1-800-368-1019** or TTY **1-800-537-7697**.

Debemos asegurarnos de que todos los servicios se le presten de una manera culturalmente competente y accesible. También debemos informarle de los beneficios del plan y sus derechos de una manera que usted pueda comprender. Cada año que usted está inscrito en nuestro plan, debemos informarle de sus derechos.

- Para obtener información de una manera que usted pueda comprender, llame a Servicio al Cliente. Nuestro plan cuenta con servicios gratuitos de intérpretes a su disposición para responder preguntas en diferentes idiomas.
- Nuestro plan también puede proporcionarle materiales en otros idiomas además del inglés y en otros formatos, como en letra grande, braille o en audio. Para hacer o modificar una solicitud permanente para obtener este documento, ahora y en el futuro, en un idioma que no sea inglés o en un formato alternativo, llame a Servicio al Cliente al número que se encuentra al pie de esta página.

Si tiene alguna dificultad para obtener información de nuestro plan debido a problemas de idioma o una discapacidad y si desea presentar una queja, puede llamar a:

- Medicare al **1-800-MEDICARE (1-800-633-4227)**. Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al **1-877-486-2048**.

- A Servicio al Cliente al **1-844-368-5888**, TTY **711** (o a su servicio de retransmisión preferido), de 8 a.m. a 8 p.m., los 7 días de la semana, de octubre a marzo; de lunes a viernes, de abril a septiembre. La llamada es gratuita.
- La Oficina de Derechos Civiles al **1-800-368-1019** o TTY **1-800-537-7697**.

Section B Our responsibility to ensure that you get timely access to covered services and drugs

As a member of our plan:

- You have the right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan. You can find more information about choosing a PCP in Chapter 3 (Using the plan's coverage for your health care and other covered services).
  - Call Member Services or view the **Provider and Pharmacy Directory** online at **myuhc.com/communityplan** to learn more about network providers and which doctors are accepting new patients.
- You have the right to use a women's health specialist without getting a referral. A referral is approval from your PCP to use someone that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you cannot get services from network providers within a reasonable amount of time, we have to pay for out-of-network care.
- You have the right to get emergency care or urgently needed care without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3 (Using the plan's coverage for your health care and other covered services).

Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

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

We protect your personal health information (PHI) as required by federal and state laws.

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

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

Section C1 How we protect your PHI

We make sure that unauthorized people do not look at or change your records.

Except for the cases noted below, we do not give your PHI to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.

- We are required to release PHI to government agencies that are checking on our quality of care.
- We are required to give Medicare your PHI. If Medicare releases your PHI for research or other uses, it will be done according to Federal laws.
- We, and the health providers who take care of you, have the right to look at information about your health care. When you enrolled in the Minnesota Health Care Program, you gave your consent for us to do this. We will keep this information private according to law.

Section C2 You have a right to look at your medical records

You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records.

You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know if and how your PHI has been shared with others.

If you have questions or concerns about the privacy of your PHI, call Member Services at the number at the bottom of this page.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

THIS NOTICE SAYS HOW YOUR MEDICAL INFORMATION MAY BE USED. IT SAYS HOW YOU CAN ACCESS THIS INFORMATION. READ IT CAREFULLY.

Effective January 1, 2022.

By law, we1 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 to access your HI.

By law, we must follow the terms of this notice.

- HI is information about your health or health care services. We have the right to change our privacy practices for handling HI. If we change them, we will notify you by mail or e-mail. We will also post the new notice at this website (**myuhc.com/communityplan**). We will notify you of a breach of your HI. We collect and keep your HI to run our business. HI may be oral, written or electronic. We limit employee and service provider access to your HI. We have safeguards in place to protect your HI.

How We Collect, Use, and Share Your Information

We collect, use, and share your HI with:

- You or your legal representative.
- Government agencies.

We have the right to collect, use, and share your HI for certain purposes. This must 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.** We may collect, use, and share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may collect, use, and share your HI with your providers to help with your care.
- **For Health Care Operations.** We may suggest a disease management or wellness program. 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.** 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.** We may collect, use, and share your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.

- **For Reminders on Benefits or Care.** We may collect, use, and share your HI to send you appointment reminders and information about your health benefits.
- **For Communications to You.** We may send you emails with certain health information via unencrypted methods. There is some risk of disclosure or interception of the contents of these communications.

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

- **As Required by Law.**
- **To Persons Involved with Your Care.** This may be to a family member in an emergency. This may happen if you are unable to agree or object. If you are unable to object, we will use our best judgment. If permitted, after you pass away, we may share HI with family members or friends who helped with your care.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with 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.** 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.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.
- **For Government Functions**. This may be for military and veteran use, national security, or the protective services.
- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** To study disease or disability.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death, or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (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** if needed to give you services. Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.
- **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 Abuse

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 your HI as described here or with your written consent. We will get your written consent to share psychotherapy notes about you. 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 promotional mailings. If you let us share your HI, the recipient may further share it. You may take back your consent. To find out how, call the phone number on your ID card.

Your Rights

You have the following rights.

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **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 when a disclosure could endanger you. We take verbal requests. 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. You can have your record sent to a third party. 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. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared 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, (**myuhc.com/communityplan**).

Using Your Rights

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-844-368-5888**, or TTY/RTT **711** (or your preferred relay service).
- **To ask that we correct or amend** your HI. Depending on where you live, you can also ask us to delete your HI. 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.
- **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 the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus South Central Insurance Company; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus Wisconsin Insurance; Health Plan of Nevada, Inc.; Optimum Choice, Inc.; Oxford Health Plans (NJ), Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of River Valley; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; and UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to **https://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, 2022

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 health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-844-368-5888**, or TTY/RTT **711** (or your preferred relay service).

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[2]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Corporation.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; **gethealthinsurance.com** Agency, Inc. Genoa Healthcare, LLC; Golden Outlook, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; Optum Health Care Solutions, Inc.; OptumHealth Holdings, LLC; Optum Labs, LLC; Optum Networks of New Jersey, Inc.; Optum Women's and Children's Health, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management,

Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, Inc.; Renai Health IPA, LLC' Renai Health Management, LLC; Sanvello Health, 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; 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. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to **https://uhc.com/privacy/entities-fn-v2-en**.

Section D Our responsibility to give you information about the plan, its network providers, your covered services, and your rights and responsibilities

As a member of UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP), you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call Member Services at the number at the bottom of the page. This is a free service. Materials will be available in Spanish, Hmong, and Somali. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including:
  - Financial information
  - How the plan has been rated by plan members.
  - The results of an external quality review study from the State
  - The number of appeals made by members
  - How to leave the plan
- Our network providers and our network pharmacies, including:
  - How to choose or change primary care providers
  - Professional qualifications of our network providers, pharmacies, and other health care providers
  - How we pay providers in our network
  - Whether we use a physician incentive plan that affects the use of referral services and the type(s) of physician incentive arrangements used

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

  - Whether stop-loss protection is provided
  - Results of a member survey if one is required because of our physician incentive plan
  - A listing of our network providers and pharmacies. This is available in our online **Provider and Pharmacy Directory** on our website at **myuhc.com/communityplan** or by calling Member Services at the number at the bottom of this page for more information and to request a copy of the **Provider and Pharmacy Directory**.
- Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) and rules you must follow, including:
  - Services and drugs covered by the plan
  - Limits to your covered services and drugs
  - Rules you must follow to get covered services and drugs
- Reason a service or drug is not covered and what you can do about it (refer to Chapter 9), including asking us to:
  - Put in writing why a service or drug is not covered
  - Change a decision we made
  - Pay for a bill you got

Section E Rules against network providers charging you for services

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services or drugs, refer to Chapter 7 (Asking us to pay a bill you have gotten for covered services or drugs).

Section F Your right to leave the plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- Refer to Chapter 10 (Ending your membership in our plan) for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- If you leave our plan, you will remain in our plan's Minnesota Senior Care Plus (MSC+) plan to get your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county.

You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions.

If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services.

Section G Your right to make decisions about your health care

Section G1 Your right to know your treatment options and make 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 condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to go to another doctor before deciding on treatment.
- **Say "no."** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) tells how to ask the plan for a coverage decision.

Section G2 Your right to say what you want to happen if you are unable to make health care decisions for yourself

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

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

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

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. The Senior LinkAge Line® is an organization that gives people information about Medicare or Medical Assistance (Medicaid), including resources for getting a form at **minnesotahelp.info/**. You can also contact Member Services to ask for the form.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital.**

The hospital will ask you whether you have signed an advance directive form and whether you have it with you.

If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

Section G3 What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Office of Health Facility Complaints at the Minnesota Department of Health at **651-201-4201**, or toll-free at **1-800-369-7994**.

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

Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

Section H1 What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you have been treated unfairly – and it is **not** about discrimination for the reasons listed in Chapter 11 – or you would like more information about your rights, you can get help by calling:

- **Member Services** at the number at the bottom of this page.
- **The State Health Insurance Assistance Program.** For details about this organization and how to contact it, refer to Chapter 2 (Important phone numbers and resources).
- **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY **1-877-486-2048**. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at **medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.)
- **The Minnesota Ombudsman for Public Managed Health Care Programs.** For details about this office and how to contact them, refer to Chapter 2 (Important phone numbers and resources).

Section I Your responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, you can call Member Services at the number at the bottom of the page.

- **Read this Member Handbook** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:
  - Covered services, refer to Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to Chapters 5 and 6.

- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services at the number at the bottom of this page if you have other coverage.
- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member ID Card whenever you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Establish a relationship with a plan network primary care doctor before you become ill. This helps you and your primary care doctor understand your total health condition.
  - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Practice preventive health care. Have tests, exams, and shots recommended for you based on your age and gender.
  - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) members, Medical Assistance (Medicaid) pays for your Medicare Part A premium and for your Medicare Part B premium.
  - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) to learn how to make an appeal.)
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services at the number at the bottom of this page or notify your county social services offices.
  - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP). Chapter 1 (Getting started as a member) tells about our service area.

- We can help you figure out whether you are moving outside our service area. Because you are eligible for Medical Assistance (Medicaid) you have a special enrollment period that allows you to switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location at any time. We can let you know if we have a plan in your new area.
- Also, be sure to let Medicare and Medical Assistance (Medicaid) know your new address when you move. Refer to Chapter 2 (Important phone numbers and resources) for phone numbers for Medicare and Medical Assistance (Medicaid).
- **If you move within our service area, we still need to know**. We need to keep your membership record up to date and know how to contact you.

• Call Member Services at the number at the bottom of this page for help if you have questions or concerns.

Chapter 9

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

Introduction

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

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

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health care or long-term services and supports, you can contact the Minnesota Ombudsman.

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you are having a problem with your care, you can call the Ombudsman for Public Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service.** This chapter explains the different options you have for different problems and complaints, but you can always call the Ombudsman for Public Managed Health Care Programs to help guide you through your problem.

For more information about ombudsman programs that can help you address your concerns, refer to Chapter 2 (Important phone numbers and resources).

Table of Contents

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section A What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your covered services or drugs or payment. Medicare and Medical Assistance (Medicaid) approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section A1 About the legal terms

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

For example, we will say:

- "Making a complaint" rather than "filing a grievance"
- "Coverage decision" rather than "organization determination," "benefit determination," "at risk-determination," or "coverage determination"
- "Fast coverage decision" rather than "expedited determination"

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

Section B Where to call for help

Section B1 Where to get more information and help

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

You can get help from the Ombudsman for Public Managed Health Care Programs

If you need help, you can always call the Ombudsman for Public Managed Health Care Programs. The Ombudsman for Public Managed Health Care Programs can answer your questions and help you understand what to do to handle your problem. Refer to Chapter 2 (Important phone numbers and resources) for more information on ombudsman programs.

The Ombudsman for Public Managed Health Care Programs is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the Ombudsman for Public Managed Health Care Programs is **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service. The services are free.

You can get help from the State Health Insurance Assistance Program (SHIP)

You can also call your State Health Insurance Assistance Program (SHIP). SHIP counselors can answer your questions and help you understand what to do to handle your problem. The SHIP is not connected with us or with any insurance company or health plan. The SHIP has trained counselors in every state, and services are free. In Minnesota, the SHIP is called the Senior LinkAge Line®. The phone number for the Senior LinkAge Line® is **1-800-333-2433** or TTY MN Relay **711** or use your preferred relay service. These calls are free. The SHIP website is **seniorlinkageline.com**.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY: **1-877-486-2048**. The call is free.
- Visit the Medicare website at **medicare.gov**.

Getting help from Livanta BFCC-QIO Program

You can call Livanta BFCC directly for help with problems. Here are two ways to get help from Livanta BFCC:

- Call **1-888-524-9900** 9 a.m.–5 p.m. local time, Monday–Friday; 11 a.m.–3 p.m. local time, weekends and holidays. TTY: **1-888-985-8775**
- Visit the Livanta BFCC-QIO program website at **livantaqio.com**

Section C Problems with your benefits

Section C1 Using the process for coverage decisions and appeals or for making a complaint

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

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go to **Section D: "Coverage decisions and appeals"** on page 171.

No. My problem is not about benefits or coverage.

Skip ahead to **Section J: "How to make a complaint"** on page 207.

Section D Coverage decisions and appeals

Section D1 Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medical Assistance (Medicaid), either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

What is an appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is no longer covered by Medicare or Medical Assistance (Medicaid). If you or your doctor disagree with our decision, you can appeal.

Section D2 What is the Member Handbook booklet about?

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- Call **Member Services** at the number at the bottom of this page.

- Call the **Ombudsman for Public Managed Health Care Programs** for free help. The Ombudsman for Public Managed Health Care Programs helps people enrolled in Medical Assistance (Medicaid) with service or billing problems. The phone number is **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.
- Call the **State Health Insurance Assistance Program (SHIP)** for free help. The SHIP is an independent organization. It is not connected with this plan. In Minnesota the SHIP is called the Senior LinkAge Line®. The phone number is **1-800-333-2433** or TTY MN Relay **711** or use your preferred relay service. These calls are free.
- Talk to **your doctor or other health care provide**r. Your doctor or other health care provider can ask for a coverage decision or appeal on your behalf.
- Talk to a **friend or family member** and ask them to act for you. 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 other person to be your representative, call Member Services at the number at the bottom of this page and ask for the "Appointment of Representative" form.
  - You can also get the form by visiting **cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**. The form gives the person permission to act for you. You must give us a copy of the signed form.
- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.
  - However, **you do not have to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

Section D3 Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section E on page 174** gives you information if you have problems about services, items, or drugs (but not Medicare Part D drugs). For example, use this section if:
  - You are not getting medical care you want, and you believe our plan covers this care.
  - We did not approve services, items, or drugs (not covered by Medicare Part D) that your doctor wants to give you, and you believe this care should be covered.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- **NOTE:** Only use Section E if these are drugs **not** covered by Medicare Part D. Medical Assistance (Medicaid) covered drugs such as over the counter drugs are **not** covered by Medicare Part D. Refer to Section F on page 186 for Medicare Part D drug appeals.

– You got medical care or services you think should be covered, but we are not paying for this care.

– You got and paid for medical services or items you thought were covered, and you want to ask us to pay the provider so you can get a refund.

- **NOTE:** We do not allow our network providers to bill you for covered services and items. We pay our providers directly, and we protect you from any charges. If you paid for a service or item that you think we should have covered, contact Member Services at the number at the bottom of this page.

– You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.

- **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, you need to read Sections G and H of this chapter because special rules apply to these types of care. Refer to Sections G and H on pages 195 and 201.

– Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why, and how to ask for a review of the dismissal. This review is a formal process called an appeal.

- **Section F on page 186** gives you information about Medicare Part D drugs. For example, use this section if:
  – You want to ask us to make an exception to cover a Medicare Part D drug that is not on our Drug List.
  – You want to ask us to waive limits on the amount of the drug you can get.
  – You want to ask us to cover a drug that requires prior approval.
  – We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  – You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section G on page 195** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  – You are in the hospital and think the doctor asked you to leave the hospital too soon.

- **Section H on page 201** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Member Services at the number at the bottom of this page.

If you need other help or information, please call the Ombudsman for Public Managed Health Care Programs at **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.

Section E Problems about services, items, and drugs (not Medicare Part D drugs)

Section E1 When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long-term care services. You can also use this section for problems with drugs that are **not** covered by Medicare Part D, including Medicare Part B drugs. Medical Assistance (Medicaid) drugs such as over-the-counter drugs are **not** covered by Medicare Part D. Use Section F for Medicare Part D drug appeals.

This section tells what you can do if you are in any of the five following situations:

1. You think we cover a medical, behavioral health, or long-term care service you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to Section E2 on page 175 for information on asking for a coverage decision.

2. We did not approve care your doctor wants to give you, and you think we should have.

   What you can do: You can appeal our decision to not approve the care. Refer to Section E3 on page 177 for information on making a Level 1 Appeal.

3. You got services or items that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to Section E3 on page 177 for information on making a Level 1 Appeal.

4. You got and paid for services or items you thought were covered, and you want us to work with the provider to refund your payment.

   What you can do: You can ask us to work with the provider to refund your payment. Refer to Section E5 on page 184 for information on asking for payment.

5. We reduced or stopped your coverage for a certain service, and you disagree with our decision.

What you can do: You can appeal our decision to reduce or stop the service. Refer to Section E3 on page 177 for information on making a Level 1 Appeal.

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, special rules apply. Read Sections G or H on pages 195 and 201 to find out more.

Section E2 Asking for a coverage decision

How to ask for a coverage decision to get a medical, behavioral health or long-term care service

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: **1-844-368-5888** TTY: **711** (or your preferred relay service)
- You can fax us at: **1-888-950-1170**
- You can write to us at: P.O. Box 30769, Salt Lake City, UT 84130-0769

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you asked unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we don't give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

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

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at **1-844-368-5888** or fax us at **1-888-950-1170**. For details on how to contact us, refer to Chapter 2 (Important phone numbers and resources).
- You can also have your doctor or your representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision **only if you are asking for coverage for medical care or an item you have not yet received.** (You cannot ask for a fast coverage decision if your request is about payment for medical care or an item you already got.)
2. You can get a fast coverage decision **only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) could cause serious harm to your health or hurt your ability to function.**

- If your doctor says that you need a fast coverage decision for one of the reasons above, we will automatically give you one.
- If you ask for a fast coverage decision without your doctor's support, we will decide if you get a fast coverage decision.
  - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) instead.
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, refer to Section J on page 207.

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

Section E3 Level 1 Appeal for services, items, and drugs (not Medicare Part D drugs)

What is an Appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagree with our decision, you can appeal. You must start your appeal at Level 1.

If you need help during the appeals process, you can call the Ombudsman for Public Managed Health Care Programs at **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service. The Ombudsman for Public Managed Health Care Programs is not connected with us or with any insurance company or health plan.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to find out if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

How do I make a Level 1 Appeal?

- To start your appeal, you, your doctor or other health care provider, or your representative must contact us. You can call us at **1-844-368-5888**. For additional details on how to reach us for appeals, refer to Chapter 2 (Important phone numbers and resources).
- You can ask us for a "standard appeal" or a "fast appeal."
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
  - You can submit a request to the below address. You may also ask for an appeal by calling us at **1-844-368-5888**. The call is free.

    Medical Appeals
    Appeals and Grievance Department
    P.O. Box 6106, MS CA124-0187
    Cypress, CA 90630-0016

    Prescription Drug Appeals
    Part D Appeal and Grievance Department
    P.O. Box 6106, MS CA124-0197
    Cypress, CA 90630-0016

At a glance: How to make a Level 1 Appeal

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have 10 days to appeal** if you want to keep getting that service while your appeal is processing.
- Keep reading this section to learn about what deadline applies to your appeal.

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

Can someone else make the appeal for me?

Yes. Your doctor or other health care provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

If we don't get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

To get an Appointment of Representative form, call Member Services at the number at the bottom of this page and ask for one, or visit **cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.

If the appeal comes from someone besides you or your doctor or other health care provider, we must get the completed Appointment of Representative form before we can review the appeal.

How much time do I have to make an appeal?

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal. You should explain the reason your appeal is late when you make your appeal.

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have 10 days to appeal** if you want to keep getting that service while your appeal is processing. Read "Will my benefits continue during Level 1 appeals" on page 180 for more information.

Can I get a copy of my case file?

Yes. Ask us for a free copy by calling Member Services at the number at the bottom of this page.

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a "standard" appeal decision?

We must give you our answer within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days, for a total of 44 calendar days. If we decide we need to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 207.
- If we do not give you an answer to your appeal within 30 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens. For more information about the Level 2 Appeal process, refer to Section E4 on page 181.
- If we do not give you an answer to your appeal within 30 calendar days or by the end of the extra days (if we took them), and your problem is about coverage of a Medical Assistance (Medicaid) service or item, you can file a Level 2 – State Appeal (Medicaid Fair Hearing with the state) yourself as soon as the time is up. Your Level 1 Appeal will be complete because we would be past our deadline to respond to you.

If our answer is Yes to all or part of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug).

If our answer is 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 Entity for a Level 2 Appeal. If your problem is about coverage of a Medical Assistance (Medicaid) service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 181.

When will I hear about a "fast" appeal decision?

If you ask for a fast appeal, we will give you our answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 207.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Medical Assistance (Medicaid) service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 181.

If our answer is Yes to all or part of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

If our answer is 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 Entity for a Level 2 Appeal. If your problem is about coverage of a Medical Assistance (Medicaid) service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 181.

Will my benefits continue during Level 1 appeals?

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 have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- If you disagree with the action, you can file a Level 1 Appeal and ask to continue getting the services. 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.
- If your doctor or health care provider is filing the appeal for you and you want your service or item to continue, then your doctor or health care provider must include your written consent.

If you meet all of these conditions, we will continue to cover the service or item until your Level 1 Appeal is resolved.

Section E4 Level 2 Appeal for services, items, and drugs (not Medicare Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter.

- If your problem is about a **Medicare** service or item, we will automatically send your case to Level 2 of the appeals process after the Level 1 Appeal is complete.
- If your problem is about a **Medical Assistance (Medicaid)** service or item, you can file a Level 2 Appeal yourself. The letter will tell you how to do this. Information is also below.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by an independent organization that is not connected to the plan.

My problem is about a Medical Assistance (Medicaid) service or item. How can I make a Level 2 Appeal?

Level 2 of the appeals process for Medical Assistance (Medicaid) services is a State Appeal (Medicaid Fair Hearing with the state). You must file a Level 1 Appeal with the plan before you ask for a State Appeal (Medicaid Fair Hearing with the state).

A State Appeal (Medicaid Fair Hearing with the state) is a hearing at the State to review a decision made by the plan. You must request a hearing in writing. You may ask for a hearing if you disagree with:

- The delivery of health services;
- Enrollment in the plan;
- Denial in full or part of a claim or service;
- Our failure to act within required timelines for service authorizations and appeals; **or**

- Any other action.

You must ask for a State Appeal (Medicaid Fair Hearing with the state) **within 120 days** of the date of the plan's appeal decision.

Mail, fax, or submit your written request to:

Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941
Fax: **651- 431-7523**

Online Appeal Form: **edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG**

A Human Services Judge from the State Appeals Office will hold the hearing. Your meeting will be by telephone unless you ask for a face-to-face meeting. During your hearing, tell the Judge why you disagree with the decision made by the plan. You can ask a friend, relative, advocate, provider, or lawyer to help you.

The process can take between 30 and 90 days. If your hearing is about an urgently needed service and you need an answer faster, tell the State Appeals Office when you file your hearing request. If your hearing is about a medical necessity denial, you may ask for an expert medical opinion from an outside reviewer. There is no cost to you.

If you need help at any point in the process, call the Ombudsman for Public Managed Health Care Programs at **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.

My problem is about a Medicare service or item. What will happen at the Level 2 Appeal?

An Independent Review Entity (IRE) will carefully review the Level 1 decision and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is an independent organization hired by Medicare and is not connected with this plan. It is not a government agency. Medicare oversees its work.
- You may ask for a copy of your file by calling Member Services at the number at the bottom of this page.

The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

If you had a "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

Will my benefits continue during Level 2 appeals?

If the disputed service or item is covered by Medicare only, we will not continue to cover that service or item during your appeal. This includes drugs covered by Medicare Part D.

If the disputed service or item could be covered by Medical Assistance (Medicaid), we will continue to cover that service or item during your appeal if the following conditions are met:

- We previously approved coverage for the service or item but then decided to reduce or stop the coverage before the authorization expired. We will send you a notice before taking the action to reduce or stop your coverage.
- You file a request for a State Appeal (Medicaid Fair Hearing with the state) **within 10 calendar days of the date on our appeal resolution letter or before the intended effective date of the action,** whichever is later.
- You ask to continue getting the service.

If you meet all of these conditions, we will continue to cover the service or item until your State Appeal (Medicaid Fair Hearing with the state) is resolved. If you lose the appeal you may be billed for the service or item, but only if state policy allows this.

How will I find out about the decision?

If you had a State Appeal (Medicaid Fair Hearing with the state), the State Appeals Office will send you a written notice explaining its decision.

- If the State Appeals Office says **Yes** to part or all of what you asked for, we must promptly authorize the coverage.
- If the State Appeals Office says **No** to part or all of what you asked for, it means they agree with or affirm the plan's decision. This is called "upholding the decision."

If your Level 2 Appeal went to the Independent Review Entity (IRE), it will send you a letter explaining its decision.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

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

If you had a State Appeal (Medicaid Fair Hearing with the state) and you disagree with the ruling, you may appeal to the District Court in your county.

If your Level 2 Appeal went to the Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

Refer to Section I on page 206 for more information on additional levels of appeal.

Section E5 Payment problems

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

If you get a bill for covered services or items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

For more information, start by reading Chapter 7: "Asking us to pay a bill you have gotten for covered services or drugs." Chapter 7 describes the situations in which you may need to ask us to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay for a service or item I paid for?

Remember, if you get a bill for covered services or items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund from that provider if you followed the rules for getting services or items.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

If you paid a provider for a service or item and you think we should pay the provider instead, you are asking for a coverage decision. We will find out if the service or item you paid for is a covered service or item, and we will check if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send the provider the payment for the service or item within 60 calendar days after we get your request. We will also work with the provider to make sure that your payment is refunded.
- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal.** Follow the appeals process described in Section E3 on page 177. When you follow these instructions, please note:

- If you make an appeal for a service or item you already got and paid for yourself, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should pay for the service or item, we must send the payment to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment you asked for to the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. Refer to Section I on page 206 for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medical Assistance (Medicaid), you can ask for a State Appeal (Medicaid Fair Hearing with the state) (refer to Section E4 on page 181).

Section F Medicare Part D drugs

Section F1 What to do if you have problems getting a Medicare Part D drug or you want us to pay you back for a Medicare Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Medicare Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medical Assistance (Medicaid) may cover, such as over-the-counter drugs. **This section only applies to Medicare Part D drug appeals.**

NOTE: For drugs covered only by Medical Assistance (Medicaid), follow the process in Section E on page 174.

Can I ask for a coverage decision or make an appeal about Medicare Part D prescription drugs?

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

- You ask us to make an exception such as:
  - Asking us to cover a Medicare Part D drug that is not on the plan's Drug List
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

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

The legal term for a coverage decision about your Medicare Part D drugs is "coverage determination."

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

Which of these situations are you in?

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make a Level 1 appeal.** (This means you are asking us to reconsider.)
Start with **Section F2** on page 187. Also refer to Sections F3 and F4 on page 188.	Skip ahead to **Section F4** on page 188.	Skip ahead to **Section F4** on page 188.	Skip ahead to **Section F5** on page 191.

Section F2 What an exception is

An exception is permission to get coverage for a drug that is not normally on our **List of Covered Drugs** (Drug List) or to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask us to make an "exception."

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

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

1. Covering a Medicare Part D drug that is not on our Drug List.
   - You cannot ask for an exception to the copay or coinsurance amount we require you to pay for the drug.
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, refer to Chapter 5 (Getting your outpatient prescription drugs through the plan).
   - The extra rules and restrictions on coverage for certain drugs include:

– Being required to use the generic version of a drug instead of the brand name drug.

– Getting plan approval before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")

– Quantity limits. For some drugs, we limit the amount of the drug you can have.

The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a "formulary exception."

Section F3 Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section F5 on page 191 tells how to make an appeal if we say **No**.

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

Section F4 How to ask for a coverage decision about a Medicare Part D drug or reimbursement for a Medicare Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at **1-844-368-5888**. Include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- Read Section D on page 171 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7 (Asking us to pay a bill you have gotten for covered services or drugs) of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are asking for an exception, provide the "supporting statement." Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the "supporting statement."
- 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 then fax or mail a statement.

At a glance: How to ask for a coverage decision about a drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Medicare Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

If your health requires it, ask us to give you a "fast coverage decision"

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

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

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

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

You can get a fast coverage decision **only if you are asking for a drug you have not yet received.** (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

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 or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
  - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
  - You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 207.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, this means within 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

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

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, this means within 72 hours after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Section F5 Level 1 Appeal for Medicare Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us. Include your name, contact information, and information regarding your claim.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling the phone number located at the bottom of this page.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

At a glance: How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at the number at the bottom of this page.

The legal term for an appeal to the plan about a Medicare Part D drug coverage decision is plan "redetermination."

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

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

- If you are appealing a decision our plan made about a drug you have not yet received, 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 F4 on page 188.

The legal term for "fast appeal" is "expedited redetermination."

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check 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. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for:
  - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.
  - If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

Section F6 Level 2 Appeal for Medicare Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.

- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at the number at the bottom of this page.
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the IRE about a Medicare Part D drug is "reconsideration."

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

Section G Asking us to cover a longer hospital stay

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

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

Section G1 Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called "An Important Message from Medicare about Your Rights." If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at the number at the bottom of this page. You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. These calls are free.

Read this notice carefully and ask questions if you don't understand. The "Important Message" tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance or if you need help, call Member Services at the number at the bottom of this page or call Medicare at **1-800 MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. The call is free.
- You can also find the notice online at **cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices**.

Section G2 Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization (QIO) will do the Level 1 Appeal review to find out if your planned discharge date is medically appropriate for you.

In Minnesota, the Quality Improvement Organization (QIO) is called Livanta. To make an appeal to change your discharge date call Livanta at: **1-888-524-9900** (TTY: **1-888-985-8775**).

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. "An Important Message from Medicare about Your Rights" contains information on how to reach the Quality Improvement Organization.

- **If you call before you leave,** you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- **If you do not call to appeal,** and 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 get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, refer to Section G4 on page 199.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at **1-888-524-9900** (TTY: **1-888-985-8775**) and ask for a "fast review."

Call before you leave the hospital and before your planned discharge date.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at the number at the bottom of this page. You can also call the State Health Insurance Assistance Program (SHIP) at **1-800-333-2433** or TTY MN Relay **711** or use your preferred relay service. The call is free. Or you can call the Ombudsman for Public Managed Health Care Programs at **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.

What is a Quality Improvement Organization (QIO)?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term for "fast review" is "immediate review."

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

The legal term for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the number listed at the bottom of this page. You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY MN Relay **711** users should call **1-877-486-2048** or use your preferred relay service. Or you can find a sample notice online at **cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices**.

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, 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.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

Section G3 Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 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 stayed in the hospital after the date that your coverage for the care ended.

In Minnesota, the Quality Improvement Organization (QIO) is called Livanta. You can reach Livanta at: **1-888-524-9900** (TTY: **1-888-985-8775**).

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at **1-888-524-9900** (TTY: **1-888-985-8775**) and ask for another review.

What happens if the answer is Yes?

- We must pay you or the provider for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. 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.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

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.

Section G4 What happens if you miss an appeal deadline

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization (which is within 60 days or no later than your planned discharge date, whichever comes first), you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a "fast review."
- **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.
- It also means that we agree to pay you or the provider for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
  - If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you got after the planned discharge date.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- To make sure we were following all the rules when we said No to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

The legal term for "fast review" or "fast appeal" is "expedited appeal."

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 207 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you or the provider for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the IRE will tell you 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 a Level 3 Appeal, which is handled by a judge.

At a glance: How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

Section H What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it. When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying 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 H1 We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The written notice tells you the date we will stop covering your care and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does not mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying.

Section H2 Level 1 Appeal to continue your care

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

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section J on page 207 tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at the number at the bottom of this page. Or call your State Health Insurance Assistance Program (SHIP) at **1-800-333-2433** or TTY MN Relay **711** or use your preferred relay service. These calls are free.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Minnesota, the Quality Improvement Organization (QIO) is called Livanta. You can reach Livanta at: **1-888-524-9900** (TTY: **1-888-985-8775**). Information about appealing to the Quality Improvement Organization is also in the Notice of Medicare Non-Coverage. This is the notice you got when you were told we would stop covering your care.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at **1-888-524-9900** (TTY: **1 888-985-8775**) and ask for a "fast-track appeal."

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a "fast-track appeal." This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, refer to Section H4 on page 204.

The legal term for the written notice is "Notice of Medicare Non-Coverage." To get a sample copy, call Member Services at **1-844-368-5888** or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or refer to a copy online at **cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices**.

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

The legal term for the letter explaining why your services should end is "Detailed Explanation of Non-Coverage."

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 they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying for the care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends, then you will have to pay the full cost of this care yourself.

Section H3 Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

In Minnesota, the Quality Improvement Organization (QIO) is called Livanta. You can reach Livanta at: **1-888-524-9900** (TTY: **1-888-985-8775**). Ask for the Level 2 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.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at **1-888-524-9900** (TTY: **1-888-985-8775**) and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you or the provider for the costs of care you got 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.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to 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 a judge.

Section H4 What happens if you miss the deadline for making your Level 1 Appeal

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.
- It also means that we agree to pay you or the provider for the care you got since the date when we said your coverage would end.
- **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a "fast review."

We will give you our decision within 72 hours.

The legal term for "fast review" or "fast appeal" is "expedited appeal."

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 207 tells how to make a complaint.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.
- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says Yes** to your appeal, then we must pay you or the provider for the cost of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

At a glance: How to make a Level 2 Alternate Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

Section I Taking your appeal beyond Level 2

Section I1 Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

If you need assistance at any stage of the appeals process, you can call the Ombudsman for Public Managed Health Care Programs. The phone number is **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.

Section I2 Next steps for Medical Assistance (Medicaid) services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Medical Assistance (Medicaid). If you disagree with the ruling from the State Appeal (Medicaid Fair Hearing with the state) process, you may appeal to the District Court in your county by calling the county clerk. You have 30 days to file an appeal with District Court.

If you need help at any stage of the process, you can call the Ombudsman for Public Managed Health Care Programs at **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.

Section J How to make a complaint

Section J1 What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services at the number listed at the bottom of this page or send us a letter. Refer to Chapter 2, Section A.

There are different organizations that handle external complaints. For more information, read Section J3 on page 210.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

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

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

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the Ombudsman for Public Managed Health Care Programs at **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.

Section J2 Internal complaints

To make an internal complaint, call Member Services at the number at the bottom of this page. You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about. If you make a complaint after this 60 calendar day period, we will consider whether there is good cause for the late filing.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will 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 legal term for "fast complaint" is "expedited grievance."

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. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints 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. We will tell you in writing why we need more time.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- 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" and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

Section J3 External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: **medicare.gov/MedicareComplaintForm/home.aspx**.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**. The call is free.

You can tell the Minnesota Department of Health about your complaint

Managed Care Systems
P.O. Box 64882
St. Paul, MN 55164-0882

You can also make a complaint at
health.state.mn.us/facilities/insurance/clearinghouse/complaints

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is **1-800-368-1019**. TTY users should call **1-800-537-7697**. You can also visit **hhs.gov/ocr** for more information.

You may also have rights under the Americans with Disability Act.

You can file a complaint with the Quality Improvement Organization (QIO)

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- Or you can make your complaint to us **and** to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

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. To learn more about the Quality Improvement Organization, refer to Chapter 2, Section F.

In Minnesota, the Quality Improvement Organization (QIO) is called Livanta. The phone number for Livanta is **1-888-524-9900** (TTY: **1-888-985-8775**).

Chapter 10

Ending your membership in our plan

Introduction

This chapter tells about ways you can end your membership in our plan and your health coverage options after you leave the plan. If you leave our plan, you will still be in Medicare and Medical Assistance (Medicaid) as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook.**

Table of Contents

Section A When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) will end on December 31 and your membership in the new plan will start on January 1.
- The **Medicare Advantage Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan will start the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, such as when:

- You have moved out of our service area,
- Your eligibility for Medicaid or Extra Help has changed, **or**
- You recently moved into, currently are getting care in, or just moved out of a nursing home or a long-term care hospital.

Your membership will end on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan will end on January 31. Your new coverage will begin the first day of the next month (February 1, in this example). If you leave our plan, you can get information about your:

- Medicare options in the table in Section C1 of this chapter (Ways to get your Medicare services).
- Medical Assistance (Medicaid) services in Section C2 of this chapter (How to get your Medical Assistance (Medicaid) services).

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

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.

- State Health Insurance Assistance Program (SHIP) at **1-800-333-2433**. In Minnesota, the SHIP is called the Senior LinkAge Line®. TTY MN Relay **711** users should call **711** or use your preferred relay service. These calls are free.
- Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

NOTE: If you are in a drug management program, you may not be able to change plans. Refer to Chapter 5 (Getting your outpatient prescription drugs through the plan) for information about drug management programs.

Section B How to end your membership in our plan

When you end your membership in our plan, you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call **1 877 486-2048**. When you call **1-800-MEDICARE**, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the table in Section C of this chapter.

Section C How to get Medicare and Medical Assistance (Medicaid) services separately

Section C1 Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

1. You can change to:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage plan or a Program of All-inclusive Care for the Elderly (PACE) and stay with the current Medical Assistance (Medicaid) services	Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at **1-800-333-2433** (TTY MN Relay **711** users call **711** or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free. You will automatically be disenrolled from UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) when your new plan's coverage begins. If you choose to leave our plan, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county. You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions. If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services.

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare prescription drug plan and stay with the current Medical Assistance (Medicaid) services	Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at **1-800-333-2433** (TTY MN Relay **711** users call **711** or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free. You will automatically be disenrolled from UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) when your Original Medicare coverage begins. If you choose to leave our plan, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county. You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions. If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services.

3. You can change to:	Here is what to do:
Original Medicare without a separate Medicare prescription drug plan and stay with the current Medical Assistance (Medicaid) services **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the Senior LinkAge Line® at **1-800-333-2433** (TTY users call **711** or use your preferred relay service).	Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at **1-800-333-2433** (TTY MN Relay **711** users call **711** or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free. You will automatically be disenrolled from UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) when your Original Medicare coverage begins. If you choose to leave our plan, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county. You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions. If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services.

Section C2 How to get your Medical Assistance (Medicaid) services

If you leave our plan, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services.

You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. Contact your county financial worker if you have questions.

If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section D How to keep getting your medical services and drugs through our plan until your membership ends

If you leave UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP), it may take time before your membership ends and your new Medicare and Medical Assistance (Medicaid) coverage begins. During this time, keep getting your prescription drugs and health care through our plan.

- **Use our network providers to receive medical care.**
- **Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership in UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) ends, our plan will cover your hospital stay until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

Section E Other situations when your membership will end

These are the cases when UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) must end your membership in the plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medical Assistance (Medicaid). Our plan is for people who qualify for both Medicare and Medicaid.
  - If you have Medicare and lose eligibility for Medical Assistance (Medicaid), our plan will continue to provide plan benefits for up to three months.
  - If after three months you have not regained Medical Assistance (Medicaid), coverage with our plan will end.
  - You will need to choose a new Medicare Part D plan in order to continue getting coverage for Medicare covered drugs.
  - If you need help, you can call the Senior LinkAge Line® at **1-800-333-2433** (TTY MN Relay **711** users call **711** or use your preferred relay service). These calls are free.
- If you do not pay your medical spenddown, as applicable.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medical Assistance (Medicaid) first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to arrange medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Section F Rules against asking you to leave our plan for any health-related reason

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week. You should also call the Ombudsman for Public Managed Health Care Programs at **651-431-2660** or **1-800-657-3729**. TTY MN Relay **711** users should call **1-800-627-3529** or **711** or use your preferred relay service. These calls are free.

Section G Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for information about how to make a complaint.

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section H How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

Chapter 11

Legal notices

Introduction

This chapter includes legal notices that apply to your membership in UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP). Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook.**

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Section A Notice about laws

Many laws apply to this **Member Handbook**. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medical Assistance (Medicaid) programs. State laws about the Medical Assistance (Medicaid) program also apply. Other federal and state laws may apply too.

Section B Notice about nondiscrimination

Every company or agency that works with Medicare and Medical Assistance (Medicaid) must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, sex, or sexual orientation. In addition, we don't treat you differently because of your marital status, medical condition, political beliefs, public assistance status, or receipt of health services.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at **1-800-368-1019**. TTY users can call **1-800-537-7697**. You can also visit **hhs.gov/ocr** for more information.
- Contact the Office for Civil Rights, Midwest Region, at 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. You can also call the toll-free numbers above, fax **1-202-619-3818**, or email ocrmail@hhs.gov.
- Call the Minnesota Department of Human Rights (MDHR) at **1-800-657-3704**. TTY users can call **711** (or your preferred relay service). These calls are free. You can also visit **mn.gov/mdhr** for more information.

If you have a disability and need help accessing health care services or a provider, call Member Services at the number at the bottom of this page. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section C Notice about Medicare as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

Section D Third party liability and subrogation

If you suffer an illness or injury for which any third party is alleged to be liable or responsible due to any negligent or intentional act or omission causing illness or injury to you, you must promptly notify us of the illness or injury. We will send you a statement of the amounts we paid for services provided in connection with the illness or injury. If you recover any sums from any third party, we shall be reimbursed out of any such recovery from any third party for the payments we made on your behalf, subject to the limitations in the following paragraphs.

1. **Our payments are less than the recovery amount.** If our payments are less than the total recovery amount from any third party (the "recovery amount"), then our reimbursement is computed as follows:
   a. **First:** Determine the ratio of the procurement costs to the recovery amount (the term "procurement costs" means the attorney fees and expenses incurred in obtaining a settlement or judgment).
   b. **Second:** Apply the ratio calculated above to our payment. The result is our share of procurement costs.
   c. **Third:** Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.
2. **Our payments equal or exceed the recovery amount.** If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.
3. **We incur procurement costs because of opposition to our reimbursement.** If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
   a. Our payments made on your behalf for services; or
   b. the recovery amount, minus the party's total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment or verdict. You may be required by us and you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

Section E Member liability

In the event we fail to reimburse provider's charges for covered services, you will not be liable for any sums owed by us. Neither the plan nor Medicare will pay for non-covered services except for the following eligible expenses:

? **If you have questions,** please call UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

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

Section F Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your plan, unless otherwise listed as a covered service. A service is "reasonable and necessary" if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
2. Furnished in a setting appropriate to the patient's medical needs and condition;
3. Ordered and furnished by qualified personnel;
4. One that meets, but does not exceed, the patient's medical need; and
5. At least as beneficial as an existing and available medically appropriate alternative.

Section G Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits

over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership.**

Section H Acts beyond our control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, network providers may become unavailable to arrange or provide health services pursuant to this Member Handbook and Disclosure Information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any network provider shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

Section I Contracting medical providers and network hospitals are independent contractors

The relationships between us and our 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 UnitedHealthcare Insurance Company or one of its affiliates. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare Insurance Company or one of its affiliates is an employee or agent of the network providers or network hospitals.

Section J Technology assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual member, one of our Medical Directors makes a medical necessity determination based on individual member medical documentation, review

of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

Section K Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered services under this Member Handbook or be used in defense of a legal action unless it is contained in a written application.

Section L Information upon request

As a plan member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals
- The financial condition of UnitedHealthcare Insurance Company or one of its affiliates

Section M 2023 Enrollee Fraud & Abuse Communication

2023 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 AARP® Medicare Advantage (HMO-POS) Customer Service at **1-800-643-4845** (TTY **711**), 24 hours a day, 7 days a week.

This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization will not take any action against you for reporting a potential fraud case in good faith.

You may also report potential medical or prescription drug fraud cases to the Medicare Drug Integrity Contractor (MEDIC) at **1-877-7SafeRx (1-877-772-3379)** or to the Medicare program directly at (**1-800-633-4227**). The Medicare fax number is **1-717-975-4442** and the website is **medicare.gov**.

Section N Commitment

UnitedHealthcare's Clinical Services Staff and Physicians make decisions on the health care services you receive based on the appropriateness of care and service and existence of coverage. Clinical Staff and Physicians making these decisions: 1. Do not specifically receive reward for issuing non-coverage (denial) decisions; 2. Do not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services; and 3. Do not hire, promote, or terminate physicians or other individuals based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Section O Renew Active™ Terms and Conditions

Eligibility Requirements

Only members enrolled in a participating Medicare Plan insured by UnitedHealthcare Insurance Company ("UnitedHealthcare") and affiliates are eligible for the Renew Active program ("Program"), which includes, without limitation, access to standard fitness memberships at participating gyms/fitness locations, online fitness and cognitive providers, digital communities, events, classes and discounts for meal delivery at no additional cost. By enrolling in the Program, you hereby accept and agree to be bound by these Terms and Conditions.

Enrollment Requirements

Membership and participation in the Program is voluntary. You must enroll in the Program according to the instructions provided on this website. Once enrolled, you must obtain your confirmation code and use it when signing up for any Program services. Provide your confirmation code when visiting a participating gym/fitness location to receive standard membership access at no additional cost, registering with an online fitness and/or cognitive providers, joining the Fitbit®

Community for Renew Active, and to gain access to included discounts. Please note, that by using your confirmation code, you are electing to disclose that you are a Renew Active member with a participating UnitedHealthcare Medicare plan.

Program enrollment is on an individual basis and the Program's waived monthly membership rate for standard membership services at participating gyms and fitness locations is only applicable to individual memberships. You are responsible for any and all non-covered services and/or similar fee-based products and services offered by Program service providers (including, without limitation, gym/fitness centers, digital fitness offerings, digital cognitive providers, Fitbit, and other third party service offerings made available through the Program), including, without limitation, fees associated with personal training sessions, specialized classes, enhanced facility membership levels beyond the basic or standard membership level, and meal delivery. Fitness membership equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Access to gym and fitness location network may vary by location and plan.

Liability Waiver

Always seek the advice of a doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Certain services, discounts, classes, events, and online fitness offerings are provided by affiliates of UnitedHealthcare or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services are subject to your acceptance of their respective terms and policies. UnitedHealthcare and its respective subsidiaries are not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. UnitedHealthcare and its respective subsidiaries and affiliates do not endorse and are not responsible for the services or information provided by third parties, the content on any linked site, or for any injuries you may sustain while participating in any activities under the Program.

Other Requirements

You must verify that the individual gym/fitness location or service provider participates in the Program before enrolling. If a Program service provider you use, including a gym or fitness location, ceases to participate in the Program, your Program participation and waived monthly membership rate with such service provider through the Program will be discontinued until you join another service offered by a participating service provider. You will be responsible for paying the standard membership rates of the such service provider should you elect to continue to receive services from a service provider once that service provider ceases to participate in our Program. If you wish to cancel your membership with such service provider, you can opt to do so per the cancellation policy of the applicable service provider, including the applicable gym or fitness location. You should review your termination rights with a service provider when you initially elect to sign up with such service provider.

Data Requirements

Optum (the Program administrator) and/or your service provider will collect and electronically send and/or receive the minimum amount of your personal information required in order to facilitate the Program in accordance with the requirements of applicable laws, including privacy laws. Such required personal information includes, but is not limited to, program confirmation code, gym/fitness location/provider membership ID, activity year and month, and monthly visit count. By enrolling in the Program, you authorize Optum to request, and each service provider to provide, such personal information.

Chapter 12

Definitions of important words

Introduction

This chapter includes key terms used throughout the **Member Handbook** with their definitions. These terms may also be used in other member documents. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Actions: These include:

- Denial or limited authorization of type or level of service
- Reduction, suspension, or stopping of a service that was approved before
- Denial of all or part of a payment or service
- Not providing services in a reasonable amount of time
- Not acting within required time frames for grievances or appeals
- Denial of member's request to get services out of network for members living in a rural area with only one health plan

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Anesthesia: Drugs that make you fall asleep for an operation.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) explains appeals, including how to make an appeal.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same active ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need

Care plan: A plan for what health services you will get and how you will get them.

Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 (Important phone numbers and resources) explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Direct access services: You can use any provider in our plan's network to get these services. You do not need a referral or prior authorization before getting services.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tiers: Groups of drugs on our **List of Covered Drugs** (Drug List). Generic, brand, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of 3 tiers. All drugs in the same tier level have the same copay. Refer to the Drug List for more information and examples.

Dual eligible individual: A person who qualifies for Medicare and Medicaid coverage.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function.

The medical symptoms may be a serious injury or severe pain. This is also called an emergency medical condition.

Emergency care/services: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency. This is also called emergency room care.

Emergency medical transportation: Ambulance services, including ground and air transportation for an emergency medical condition

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Excluded services: Services the plan does not pay for. Medicare and Medical Assistance (Medicaid) will not pay for them either.

External Quality Review Study: A study about how quality, timeliness and access of care are provided by UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP). This study is external and independent.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-income subsidy," or "LIS."

Family planning: Information, services and supplies to help a person decide about having children. These decisions include choosing to have a child, when to have a child or not to have a child.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Health plan: An organization that has a network of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all of your providers and services. They all work together to provide the care you need.

Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.

Home and Community-Based Services (HCBS): Additional services that are provided to help you remain in your home.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care: Health care services for an illness or injury given in your home or in the community where normal life activities take the member.

Housing Stabilization Services: Services to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. The purpose of these services is to support a person's transition into housing, increase long-term stability in housing in the community, and avoid future periods of homelessness or institutionalization.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

- A member who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) must give you a list of hospice providers in your geographic area.
- This is also known as Hospice Services.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital outpatient care: Care in a hospital that usually doesn't require an overnight stay. An overnight stay for observation could be outpatient care.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member ID Card when you get any services or prescriptions. Call Member Services at the number at the bottom of this page if you get any bills you do not understand.

Because UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services. If you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

List of Covered Drugs (Drug List): A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): Long-term services and supports are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing home or hospital.

Low-income subsidy (LIS): Refer to "Extra Help."

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- Refer to Chapter 2 (Important phone numbers and resources) for information about how to contact Medicaid in your state. In Minnesota, Medicaid is called Medical Assistance.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:

- be the services that other providers would usually order.
- help you get better or stay as well as you are.
- help stop your condition from getting worse.
- help prevent and find health problems.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage Plan: A Medicare program, also known as "Medicare Part C" or "MA Plans," that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Medicare Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dually eligible individual."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Medicare Part D drugs. Medicaid may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Medical Assistance (Medicaid) who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Handbook and Disclosure Information: This document, along with your enrollment form and any other attachments or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. Refer to Chapter 2 (Important phone numbers and resources) for information about how to contact Member Services.

Minnesota Senior Care Plus (MSC+): A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance (Medicaid) enrollees age 65 and older.

Minnesota Senior Health Options (MSHO): A program in which the State and CMS contract with health plans, including our plan, to provide services only for seniors eligible for both Medicare and Medical Assistance (Medicaid), including those covered by MSC+.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network providers: These are providers who agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called plan providers or participating providers.

Notice of Action: A form or letter we send to you telling you about a decision on a claim, a service or any other action taken by our plan. This is also called a Denial, Termination, or Reduction (DTR).

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Nursing home certifiable: A decision that you need a nursing home level of care. A screener uses a process called a Long Term Care Consultation to decide.

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman or Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman's/ombudsperon's services are free. You can find more information about the ombudsman/ombudsperson in Chapters 2 (Important phone numbers and resources) and 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) of this handbook.

Open access services: Federal and state law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency – even if not in our plan's network – to get these services.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this handbook. Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out of network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3 (Using the plan's coverage for your health care and other covered services) explains out-of-network providers or facilities. This is also known as a non-participating provider.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a health care professional.

Palliative care: Palliative care helps people with serious illnesses feel better. It prevents or treats symptoms and side effects of disease and treatment. Palliative care also treats emotional, social, practical, and spiritual problems that illnesses can bring up. Palliative care can be given at the same time as treatments meant to cure or treat the disease. Palliative care may be given when the

illness is diagnosed, throughout treatment, during follow-up, and at the end of life.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP)'s Notice of Privacy Practices for more information about how UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Physician services: Health care services provided or coordinated by a medical physician licensed under state law (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).

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.

Prescription drugs: Drugs and medications that can be dispensed only with an order given by a properly authorized person.

Primary care clinic (PCC): The facility where you get most of the health care services you need, such as annual checkups, and helps coordinate your care. You may need to choose a primary care clinic when you enroll in our plan.

Primary care provider (PCP): Your primary care provider is the doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to Chapter 3 (Using the plan's coverage for your health care and other covered services) for information about getting care from primary care providers.

Prior authorization: An approval from UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) you must get before you can get a specific service or drug or use an out-of-network provider. UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) may not cover the service or drug if you don't get approval.

Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan.

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- Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4, Section D.

Some drugs are covered only if you get prior authorization from us.

- Covered drugs that need prior authorization are marked in the **List of Covered Drugs** (Drug List).

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not 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.

Provider: The general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to members. Refer to Chapter 2 (Important phone numbers and resources) for information about how to contact the QIO for your state.

Quality of care complaint: In this handbook, "quality of care complaint" means an expressed dissatisfaction about health care services resulting in potential or actual harm to a member. Complaints may be about access; provider and staff competence; clinical appropriateness of care; communications; behavior; facility and environmental considerations; and other factors that can have a negative effect on the quality of health care services.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

Referral: A referral means that your primary care provider (PCP) must give you approval before you can use someone that is not your PCP. If you don't get approval, UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) may not cover the services. You don't need a referral for certain specialists, such as women's health specialists. You can find more information about referrals in Chapter 3 (Using the plan's coverage for your health care and other covered services) and about services that require referrals in Chapter 4 (Benefits Chart).

Rehabilitation services and devices: Treatment and equipment you get to help you recover from an illness, accident or major operation. Refer to Chapter 4 (Benefits Chart) to learn more about rehabilitation services.

Restricted Recipient Program: A program for members who got medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from one designated primary care provider, one clinic, one hospital used by the primary care provider, and one pharmacy. UnitedHealthcare may designate other health care providers. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail

to follow program rules will be required to continue in the program for an additional 36 months. The restricted recipient program does not apply to Medicare-covered services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP).

Skilled nursing care: Care or treatment that can only be given by licensed nurses.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Appeal (Medicaid Fair Hearing with the state): A hearing at the state to review a decision made by our plan. You must ask for a hearing in writing. You may ask for a hearing if you disagree with any of the following:

- A denial, termination or reduction of service
- Enrollment in the Plan
- Denial in full or part of a claim or service
- Our failure to act within required timelines for prior authorization and appeals
- Any other action

State Medicaid agency: In Minnesota, this agency is the Minnesota Department of Human Services.

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Subrogation: Our right to collect money in your name from another person, group, or insurance company. We have this right when you get medical coverage under this plan for a service that is covered by another source or third party payer.

Substance use disorder: Using alcohol or drugs in a way that harms you.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

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UnitedHealthcare Dual Complete® ONE (HMO-POS D-SNP) Member Services

Call **1-844-368-5888**
The call is free.
8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September
Member Services also has free language interpreter services available for non-English speakers.

TTY **711** (or your preferred relay service)
The call is free.
8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September

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

myuhc.com/communityplan

Senior LinkAge Line®, Minnesota's SHIP

Senior LinkAge Line® is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare in Minnesota.

Call **1-800-333-2433**
The call is free.

Call the Minnesota Relay Service at 711 or use your preferred relay service.
The call is free.

Write: **Minnesota Board on Aging**
PO Box 64976
St. Paul, MN 55164-0976

seniorlinkageline.com

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