Member Handbook 2023

UnitedHealthcare Connected® (Medicare-Medicaid Plan)

Toll-free **1-800-256-6533**, TTY **711**
8 a.m.–8 p.m. local time, M–F

UHCCommunityPlan.com
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United Healthcare Community Plan

TEXAS Health and Human Services

TEXAS Medicare Medicaid PLAN
Your Health Plan ★ Your Choice

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UnitedHealthcare Connected® (Medicare-Medicaid Plan)

Member Handbook

January 1, 2023 – December 31, 2023

Your health and drug coverage under the UnitedHealthcare Connected® Medicare-Medicaid Plan

Member Handbook introduction

This handbook tells you about your coverage under UnitedHealthcare Connected® through December 31, 2023. It explains 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. We are offering both your Medicare and Texas Medicaid covered benefits. 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 Connected® plan is offered by UnitedHealthcare Community Plan of Texas, LLC. When this **Member Handbook** says “we,” “us,” or “our,” it means UnitedHealthcare. When it says “the plan” or “our plan,” it means UnitedHealthcare Connected.®

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

ATENCIÓN: Si habla español, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al **1-800-256-6533** (TTY **711**), de 8 a.m. a 8 p.m., hora local, de lunes a viernes. La llamada es gratuita.

- UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.
- UnitedHealthcare provides free services to help you communicate with us such as letters in other languages, braille, large print, audio, or you can ask for an interpreter. Please contact our Member Services number at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F, for additional information.

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

Disclaimers

UnitedHealthcare Connected® (Medicare - Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

Coverage under UnitedHealthcare Connected® 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.

? **If you have questions,** please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. The call is free. **For more information,** visit **UHCCommunityPlan.com**.

The NurseLine service should not be used for emergency or urgent care needs. In an emergency, call **911** or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.

? **If you have questions,** please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. The call is free. **For more information,** visit **UHCCommunityPlan.com**.

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Chapter 1

Getting started as a member

Introduction

This chapter includes information about UnitedHealthcare Connected®, a health plan that covers all your Medicare and Texas Medicaid services, and your membership in it. It also tells you what to expect and what other information you will get from UnitedHealthcare Connected®. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

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Section A Welcome to UnitedHealthcare Connected® (Medicare-Medicaid Plan)

UnitedHealthcare Connected® is a Medicare-Medicaid Plan. A *Medicare-Medicaid Plan* is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports (LTSS), and other providers. It also has Service Coordinators and service coordination teams to help you manage all your providers and services. They all work together to provide the care you need.

UnitedHealthcare Connected® was approved by the State of Texas and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the Texas Dual Eligibles Integrated Care Demonstration Project.

The Texas Dual Eligibles Integrated Care Demonstration Project is a demonstration program jointly run by Texas and the federal government to provide better health care for people who have both Medicare and Texas Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Texas Medicaid health care services.

Section B Information about Medicare and 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 Texas Medicaid

Texas 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.

Each state has its own Medicaid program and 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 the State of Texas must approve UnitedHealthcare Connected® each year. You can get Medicare and Texas Medicaid services through our plan as long as:

- you are eligible to participate in the Texas Dual Eligibles Integrated Care Demonstration Project;
- we offer the plan in your county, **and**
- Medicare and the State of Texas approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Texas Medicaid services will not change.

Section C Advantages of this plan

You will now get all your covered Medicare and Texas Medicaid services from UnitedHealthcare Connected®, including prescription drugs. **You do not pay extra to join this health plan.**

UnitedHealthcare Connected® will help make your Medicare and Texas 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 service coordination team that you helped put together. Your service coordination 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 Service Coordinator. This is a person who works with you, with UnitedHealthcare Connected®, 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 service coordination team and Service Coordinator.
- The service coordination team and Service Coordinator will work with you to come up with a Plan of Care specifically designed to meet your health needs. The service coordination team will be in charge of coordinating the services you need. This means, for example:
  - Your service coordination team will make sure your doctors know about all medicines you take so they can reduce any side effects.
  - Your service coordination team will make sure your test results are shared with all your doctors and other providers.

Section D UnitedHealthcare Connected®'s service area

Our service area includes this county in Texas: Harris County.

Only people who live in this county in our service area can get UnitedHealthcare Connected®.

If you move outside of our service area, you cannot stay in this plan. Refer to Chapter 8 Section J 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 are age 21 or older, **and**
- you live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it), **and**
- you have both Medicare Part A and Medicare Part B, **and**
- you are a United States citizen or are lawfully present in the United States, **and**
- you are eligible for Texas Medicaid and **at least one** of the following:
  - have a physical disability or a mental disability and qualify for Supplemental Security Income (SSI), or
  - qualify for Texas Medicaid because you receive Home and Community-based Services (HCBS) waiver services; **and**
- you are NOT enrolled in one of the following 1915(c) waiver programs:
  - Community Living Assistance and Support Services (CLASS)
  - Deaf Blind with Multiple Disabilities Program (DBMD)
  - Home and Community-based Services (HCBS)
  - Texas Home Living Program (TxHmL)

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 90 days.

You will get a phone call from a Service Coordinator to do a welcome call assessment.

If UnitedHealthcare Connected® is new for you, you can keep using the doctors you use now for 90 days or until the new health risk assessment is finished.

After 90 days for most services, but six months for long-term services and supports (LTSS), you will need to use doctors and other providers in the UnitedHealthcare Connected® network. A network provider is a provider who works with the health plan. Refer to Chapter 3 for more information on getting care.

Section G Your Plan of Care

Your **Plan of Care** is the plan for what health services you will get and how you will get them.

After your health risk assessment, your service coordination team will meet with you to talk about what health services you need and want. Together, you and your service coordination team will make your Plan of Care.

Every year, your service coordination team will work with you to update your Plan of Care if the health services you need and want change.

All members will have a Plan of Care. If you qualify for HCBS (STAR+PLUS) waiver services you will also have an Individual Service Plan.

Section H UnitedHealthcare Connected® monthly plan premium

UnitedHealthcare Connected® 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, or call **1-800-MEDICARE (1-800-633-4227)**.

You can ask for a **Member Handbook** by calling Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. You can also refer to the **Member Handbook** at **UHCCommunityPlan.com** or download it from this website.

The contract is in effect for the months you are enrolled in UnitedHealthcare Connected® between January 1, 2023 and December 31, 2023.

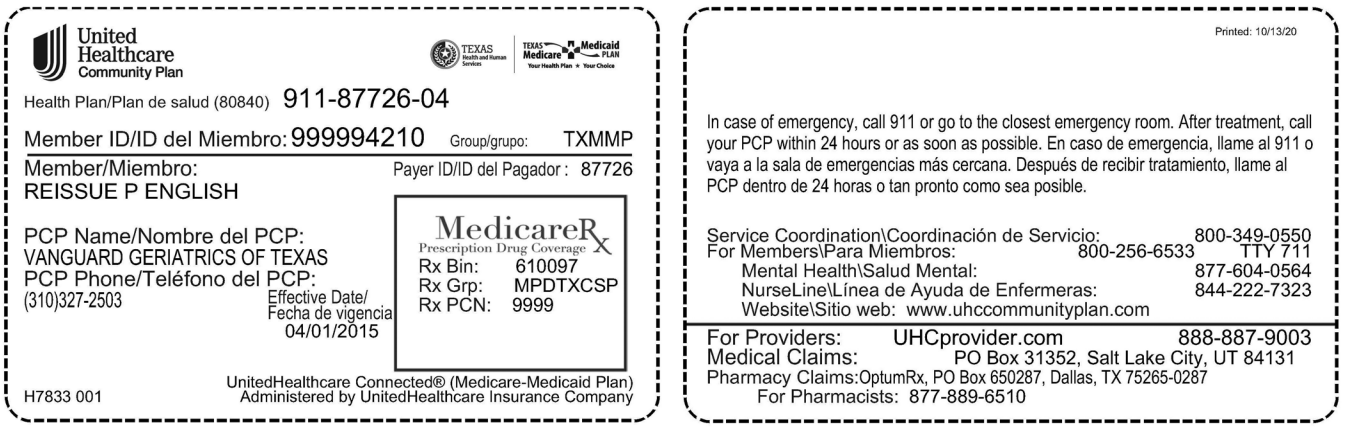
Section J Other important information you will get from us

You should have already gotten a UnitedHealthcare Connected® Member ID Card, information about how to access a **Provider and Pharmacy Directory**, and a **List of Covered Drugs**.

Section J1 Your UnitedHealthcare Connected® Member ID Card

Under our plan, you will have one card for your Medicare and Texas Medicaid services, including LTSS 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 you have questions,** please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. The call is free. **For more information,** visit **UHCCommunityPlan.com**.



If your card is damaged, lost, or stolen, call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.-8 p.m. local time, M–F 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 Texas Benefits 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 Connected® Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7 to find out what to do if you get a bill from a provider. **The only exception is, that you will use your Original Medicare card if you need hospice care.**

Section J2 Provider and Pharmacy Directory

The **Provider and Pharmacy Directory** lists the providers and pharmacies in the UnitedHealthcare Connected® 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 (refer to page 8).

- You can ask for a **Provider and Pharmacy Directory** by calling Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. You can also refer to the **Provider and Pharmacy Directory** at **UHCCommunityPlan.com**, or download it from this website.

This Directory lists health care professionals (such as doctors, nurse practitioners, and psychologists), facilities (such as hospitals or clinics), and support providers (such as Adult Day Health and Home Health providers) that you may see as a UnitedHealthcare Connected® member. We also list the pharmacies that you may use to get your prescription drugs.

Definition of network providers

UnitedHealthcare Connected®'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 (DME) suppliers, and others who provide goods and services that you get through Medicare or Texas 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.

Call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F, for more information. Both Member Services and UnitedHealthcare Connected®'s website can give you the most up-to-date information about changes in our network pharmacies and providers.

Section J3 List of Covered Drugs

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 Connected®.

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 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 **UHCCommunityPlan.com** or call **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

Section J4 The Explanation of Benefits

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

The EOB tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. Chapter 6 gives more information about the EOB and how it can help you keep track of your drug coverage.

? **If you have questions,** please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. The call is free. **For more information,** visit **UHCCommunityPlan.com**.

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
- Admission to a nursing home or hospital
- 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 a 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 **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

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 medical records and PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, refer to Chapter 8, Section D.

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 Connected® and your health care benefits. You can also use this chapter to get information about how to contact your Service 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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Section A How to contact UnitedHealthcare Connected® Member Services

Method	Member services — Contact information
Call	**1-800-256-6533**. This call is free. 8 a.m.–8 p.m. local time, M–F. After hours, please call our NurseLine at **1-844-222-7323**. Call **911** or go to the nearest hospital or emergency facility if you think you need emergency care. We have free interpreter services for people who do not speak English.
TTY	**711**. This call is free. 8 a.m.–8 p.m. local time, M–F. After hours, please call our NurseLine at **1-844-222-7323**.
Write	For general questions or concerns: UnitedHealthcare Community Plan PO Box 6103 MS CA124-0187 Cypress, CA 90630 Please call us first at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F if you have a concern. If you are mailing us an appeal or complaint about your medical care or a complaint (not an appeal) about your Texas Medicaid drugs (drugs marked with an asterisk (*) in our Drug List) or Part D drugs, please address it to "UnitedHealthcare Complaint and Appeals Department" at the above address. If you are sending us an appeal (not a complaint) about your Texas Medicaid drugs (drugs marked with an asterisk (*) in our Drug List) or Part D prescription drugs, please write to us at: UnitedHealthcare Community Plan Attn: Part D/Texas Medicaid Standard Appeals PO Box 6103 Cypress, CA 90630
Website	**UHCCommunityPlan.com**

Section A1 When to contact Member Services

- Questions about the plan
- Questions about claims, billing or Member ID Cards
- 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 services.

    - Call us if you have questions about a coverage decision about health care.

      – To learn more about coverage decisions, refer to Chapter 9.
- Appeals about your health care

  An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.

  – To learn more about making an appeal, refer to Chapter 9.
- Complaints about your health care

  You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with 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).

  – 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 Connected® 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)** to ask for help.

  – To learn more about making a complaint about your health care, refer to Chapter 9.
- 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 Part D drugs, Texas Medicaid prescription drugs, and Texas Medicaid over-the-counter drugs.

  – For more on coverage decisions about your prescription drugs, refer to Chapter 9.

- Appeals about your drugs

  An appeal is a way to ask us to change a coverage decision.

  – For more on making an appeal about your prescription drugs, refer to Chapter 9.

- 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 Connected® 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)** to ask for help.

  – For more on making a complaint about your prescription drugs, refer to Chapter 9.

- **Payment for health care or drugs you already paid for**
  - If you believe that you should be paid back for Texas Medicaid-covered benefits that you already paid for, please call Member Services for help at **1-800-256-6533** (TTY **711**).
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to Chapter 7.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Chapter 9 for more on appeals.

Section B How to contact your Service Coordinator

Service coordination is a service UnitedHealthcare Community Plan gives you to help with your health and well-being. A Service Coordinator will review, plan and help you in meeting your health care coverage needs. To get in touch with a Service Coordinator, look on your Member ID Card for the phone number. You can also call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.-8 p.m. local time, M–F to help you reach your Service Coordinator. Our goal is to find a Service Coordinator that is a good fit for your needs; but, if you want to change your Service Coordinator you can call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

Method	Service Coordinator — Contact information
Call	**1-800-256-6533**. This call is free. 8 a.m.–8 p.m. local time, M–F. After hours, please call our NurseLine at **1-844-222-7323**. We have free interpreter services for people who do not speak English.
TTY	**711**. This call is free. 8 a.m.–8 p.m. local time, M–F. After hours, please call our NurseLine at **1-844-222-7323**.
Write	UnitedHealthcare Community Plan 14141 Southwest Freeway, Suite 500 Sugar Land, TX 77478

Section B1 When to contact your Service Coordinator

- Questions about your health care
- Questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)

  – Please talk to your Service Coordinator about getting LTSS.

  Sometimes you can get help with your daily health care and living needs. You might be able to get these services:

  – Skilled nursing care

  – Physical therapy

  – Occupational therapy

  – Speech therapy

  – Medical social services

? **If you have questions,** please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. The call is free. **For more information,** visit **UHCCommunityPlan.com**.

- Home health care
- Durable medical equipment
- Medical supplies
- Help with getting a medical or dental visit

Section C How to contact the Nurse Advice Call Line

As a member of UnitedHealthcare Connected®, you can take advantage of our Nurse Advice Call Line services provided through NurseLine. NurseLine gives you access to experienced registered nurses (RNs) who are trained to understand your health care needs and concerns.

Method	NurseLine — Contact information
Call	**1-844-222-7323**. This call is free. The NurseLine is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	**711**. This call is free. The NurseLine is available 24 hours a day, 7 days a week, 365 days a year.

Section C1 When to contact the Nurse Advice Call Line

- Questions about your health care

Section D How to contact the Behavioral Health and Substance Abuse Crisis Line

UnitedHealthcare Connected® covers medically necessary behavioral health services. If you have a drug problem or are very upset about something, you can get help. Call **1-877-604-0564** for help. You do not need a referral for these services.

There will be people who can speak with you in English or Spanish. If you need help with other languages, please tell them. Member Services will connect you to the Language Line and answer your questions. Please call TTY **711**, for hearing impaired.

If it is a crisis and you have trouble with the phone line, call **911** or go to the nearest emergency room and call UnitedHealthcare Connected® within 24 hours.

Method	Behavioral Health and Substance Abuse Crisis Line — Contact information
Call	**1-877-604-0564**. This call is free. The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	**711**. This call is free. The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year.

Section D1 When to contact the Behavioral Health and Substance Abuse Crisis Line

- Questions about behavioral health services
- Questions about substance abuse treatment services

Section E How to contact the Nonemergency Medical Transportation (NEMT) Services Line and the "Where's My Ride?" Line

Medical transport is provided for covered health care services if you have no other way to get to the doctor, live in an area with no public transport or cannot use public transport due to a health condition or disability. Please refer to the below information on how and when to contact the Nonemergency Medical Transportation (NEMT) Services Line and the "Where's My Ride?" Line.

Remember to schedule rides as early as possible, and at least two business days before you need the ride.

Section E1 When to contact the NEMT Services Line

Method	NEMT Services Line — Contact information
Call	**1-866-427-6607** This call is free. 8:00 a.m.–5:00 p.m., Monday–Friday We have free interpreter services for people who do not speak English.
TTY	**1-866-288-3133** This call is free. 8:00 a.m.–5:00 p.m., Monday–Friday

- Questions and help with scheduling rides to nonemergency healthcare appointments

Section E2 When to contact the "Where's My Ride?" Line

Method	Member services — Contact information
Call	**1-866-427-6608** This call is free. The "Wheres my Ride?" Line is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	**1-866-288-3133** This call is free. 8:00 a.m.–5:00 p.m., Monday–Friday

- Questions about the status of your scheduled ride

Section F 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 Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP).

HICAP is not connected with any insurance company or health plan.

Method	State Health Insurance Assistance Program (SHIP) — Contact information
Call	**1-800-252-3439**
Write	P.O. Box 13247 Austin, TX 78711
Website	**https://hhs.texas.gov/services/health/medicare**

Section F1 When to contact HICAP

- Questions about your Medicare health insurance

  HICAP 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 G How to contact the Quality Improvement Organization (QIO)

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

Method	KEPRO — Contact information
Call	**1-888-315-0636**
TTY	**711** This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
Write	KEPRO 5201 W Kennedy Blvd. Suite 900 Tampa, FL 33609
Website	**keproqio.com**

Section G1 When to contact KEPRO

- 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 H 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 I How to contact Texas Medicaid

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

Texas Medicaid pays for Medicare premiums for certain people, and pays for Medicare deductibles, coinsurance and copayments. Texas Medicaid covers long term care services such as home and community based "waiver" services and assisted living services and long term nursing home care. It also covers dental and vision services.

You are enrolled in Medicare and in Texas Medicaid. If you have questions about the help you get from Texas Medicaid, call Texas Medicaid.

Method	Texas Medicaid — Contact information
Call	For general information: **1-800-252-8263** or **2-1-1**
TTY	**1-800-735-2989** or **7-1-1**
Write	4900 N. Lamar Blvd P.O. Box 13247, Austin, TX 78751
Website	**https://hhs.texas.gov/about-hhs/find-us**

Method	Texas Medicaid — Contact information
Call	For information on eligibility or coverage/services: **1-877-541-7905**
TTY	**711**
Write	4900 N. Lamar Blvd, Austin, TX 78751
Website	**yourtexasbenefits.hhsc.texas.gov/**

Section J How to contact the HHSC Office of the Ombudsman

The HHSC Office of the Ombudsman 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 HHSC Office of the Ombudsman also helps people enrolled in Texas Medicaid with service or billing problems. They are not connected with our plan or with any insurance company or health plan. The HHSC Office of the Ombudsman is an independent program and their services are free.

Method	HHSC Office of the Ombudsman — Contact information
Call	**1-866-566-8989**
TTY	**1-800-735-2989** This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
Write	Texas Health and Human Services Commission Office of the Ombudsman, MC H-700 P. O. Box 13247 Austin, TX 78711-3247
Website	**https://hhs.texas.gov/about-hhs/your-rights/hhs-office-ombudsman**

Section K How to contact the Texas Long-Term Care Ombudsman

The Texas Long-Term Care Ombudsman 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	Texas Long-Term Care Ombudsman — Contact information
Call	**1-800-252-2412**
Write	Texas LTC Ombudsman P. O. Box 149030 Austin, TX 78714-9030
Website	**https://hhs.texas.gov/about-hhs/your-rights/office-ombudsman/hhs-ombudsman-publications**

Section L Other resources

Routine Transportation

Method	Routine Transportation — Contact information
Call	ModivCare™ **1-866-427-6607** Calls to this number are free. Hours of Operation: 8 a.m.–5 p.m. local time, Monday–Friday
TTY	**1-866-288-3133** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of Operation: 8 a.m.–5 p.m. local time, Monday–Friday
Website	**modivcare.com**/

For more information about your transportation benefit, please contact ModivCare at the toll-free number or website above.

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 Connected®. It also tells you about your Service 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**.

Table of Contents

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

Services are health care, long-term services and supports, 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.

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 long-term services and supports.

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 Connected® covers all services covered by Medicare and Texas Medicaid. This includes behavioral health and long-term services and supports (LTSS).

UnitedHealthcare Connected® 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 of this handbook).
- **The care must be medically necessary.** Medically necessary means reasonable and necessary to prevent or treat illnesses or health conditions or disabilities. 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.
- **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, our plan 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 Connected® may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. To learn more about referrals, refer to Chapters 3 and 4.
  - You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, refer to page 32.

  - To learn more about choosing a PCP, refer to page 32.
- **Note:** In your first 90 days with our plan, you may continue to use your current providers, at no cost, if they are not a part of our network. During the 90 days, our Service Coordinator will contact you to help you find providers in our network. After 90 days, we will no longer cover your care if you continue to use out-of-network providers.

- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
  - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out what emergency or urgently needed care means, refer to Section I, page 40.
  - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. Please talk to your Service Coordinator to get an approval before you get this care. In this situation, we will cover the care as if you got it from a network provider. To learn about getting approval to use an out-of-network provider, refer to Section D4, page 35.
  - The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility.
  - When you first join the plan, you can continue using the providers you use now for at least 90 days.

Section C Information about your Service Coordinator

Section C1 What a Service Coordinator is

Service Coordination is a service UnitedHealthcare Connected® gives you to help with your health and well-being. A Service Coordinator will review, plan and help you in meeting your health care and health care coverage needs. You will be assigned a Service Coordinator when you join UnitedHealthcare Connected®. Your Service Coordinator will call you or visit you in person to talk to you about your health care needs and tell you more about the services you can get. They will ask you questions about your health. Please be honest and open. Your Service Coordinator will keep anything you talk about confidential.

Section C2 How you contact your Service Coordinator

To talk to your Service Coordinator, look on your UnitedHealthcare Connected® Member ID Card for the phone number. You can also call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F to help you reach your Service Coordinator.

We have free interpreter services for people who do not speak English. This call is free. Write us at UnitedHealthcare Community Plan 14141 Southwest Freeway, Suite 500 Sugar Land, TX 77478.

Section C3 How you can change your Service Coordinator

Our goal is to find a Service Coordinator that is a good fit for your needs; but, if you want to change your Service Coordinator you can call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

Section C4 What a Service Coordinator can do for you

Your Service Coordinator can help you:

- Arrange care with your Primary Care Provider.
- Help with any medical, behavioral health and Long-Term Services and Supports.
- Deal with any problems with your medical care or providers.
- Find ways to help you live at home or in other community settings.
- Explain service and placement choices to you.
- Assist with referrals to disease management programs that help with long-lasting illness such as Diabetes, Asthma, Heart Failure, COPD, Coronary Artery Disease, and Obesity.

Section D Care from primary care providers, specialists, other network providers, out-of-network providers, and how to change health plans

Section D1 Care from a primary care provider

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

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

- What a PCP is

A Primary Care Provider (PCP) is a licensed network doctor, doctor group practice, advance practice nurse, or advance practice nurse group who is picked by you to give you or coordinate your covered services. Regular checkups with your PCP are important and can help you stay healthy. Your PCP will do regular health screenings that can help find problems. Finding and treating problems early might keep them from becoming bigger problems later. Your PCP will be your main doctor from now on. Your PCP will take care of you and refer you to a specialist when needed. You should talk to your PCP about all of your health care needs.

Always talk to your PCP when you want to visit another doctor. Your PCP will give you a referral form if you need one. Your relationship with your PCP is important. Get to know your PCP as soon as possible. It is important to follow your PCP's advice. A good way to build a relationship with your PCP is to call and schedule a checkup. You can meet your PCP then. They will get to know your medical history, any medications you are taking and any other health problems.

- What types of providers can be a PCP?

  PCPs are doctors specializing in family or general practice, internal medicine, pediatrics, geriatrics and obstetrics/gynecology (OB/GYN). Sometimes, people might see other specialists who might be considered a PCP. An example might be a cardiologist; and you will work with your Service Coordinator to coordinate services. Sometimes there might be a reason that a specialist might need to be your PCP. A specialist serves as a PCP for members with very complex healthcare needs. If you and/or your specialist believe that they should be your PCP, you should talk to your Service Coordinator about this.

- Can a clinic be my primary care provider?

  A community-based clinic such as a family practice clinic, Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC), can serve as your PCP. If you pick a clinic, FQHC or RHC, the name of that clinic will appear on your Member ID Card. In this case, you can be seen by any provider within the clinic, FQHC or RHC. Some Primary Care Provider sites might have medical residents, nurse practitioners and provider assistants who will give care to you under the supervision of your PCP.

  Don't forget that your PCP is the first one you should call with any health problems or questions about your health.

How do you choose your PCP?

When you first join, we will help you pick a PCP. Member Services can help you pick a new PCP when you need it. If there is a certain specialist or hospital that you want to use, check first to see if they are in our network of providers.

For a copy of the most recent **Provider and Pharmacy Network Directory**, or for help in picking a PCP, call Member Services or use our Provider look-up tool online at **UHCCommunityPlan.com**.

Changing your PCP

You may change your PCP for any reason, at any time during the plan 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. PCP changes within the first month of being a member will start on the date you asked for it. If you request a PCP change after your first month of being a member, the change will start on the first day of the next month. You will get a new Member ID Card that shows your new PCP name and phone number.

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.

When you and your PCP agree you need to go to another doctor (specialist), they will recommend someone for you to see. **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 a network specialist for your medical condition, answer questions you have about a network specialist's treatment plan and give follow-up health care as needed. For coordination of care, we ask you to tell your PCP and your Service Coordinator when you see a network specialist. We will help the prior authorization team get any approvals needed for your covered services or drugs.

Please look in the **Provider and Pharmacy Directory** for a list of plan specialists in your network, or you can check the **Provider and Pharmacy Directory** online at the website listed in Chapter 2 of this booklet.

Learn more about network physicians/providers.

You can learn information about network physicians/providers, such as board certifications, and languages they speak, at **myuhc.com/CommunityPlan**, or by calling Member Services.

We can tell you the following information:

- Name, address, telephone numbers.
- Languages they speak.
- Professional qualifications.
- Specialty.
- Medical school attended (phone only).

- Residency completion (phone only).
- Board certification status.

Utilization Management Policy and Procedures

We have policies and steps we follow in decision-making about approving medical services. We want to make sure that the health care services provided are medically necessary, right for your condition and are provided in the best care facility. We make sure that quality care is delivered. The criteria used in our decision-making are available to you and your doctor if you ask for it. No UnitedHealthcare Community Plan employee or provider is rewarded in any way for not giving you the care or services you need or for saying that you should not get them. A Utilization Management (UM) Decision is when we look at the appropriateness, medical need and efficiency of health care services, procedures and facilities against our set criteria. Included may be: discharge planning, concurrent planning, pre-certification, approval in advance and clinical case appeals. Also, it may cover proactive processes like concurrent clinical review, peer review and appeals from a provider, payer or patient/member. There are also some treatments and procedures we need to review before you can get them. Your providers know what they are, and they take care of letting us know to review them. The review we do is called a Utilization Review. We do not reward anyone for saying no to needed care. If you have questions about UM, you can talk to our Medicaid Care Management staff. Our nurses are available 8:00 a.m. to 5:00 p.m. Monday through Friday at **1-800-256-6533**, TTY **711**. Language assistance is available.

Section D3 What to do when a network 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 for, 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 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. Please call Member Services or your Service Coordinator for help.

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

We will only pay for care you get from out-of-network providers if you have followed the rules in the **"You must get your care from network providers"** Section on page 30 in this Chapter.

- If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Texas Medicaid.
- We cannot pay a provider who is not eligible to participate in Medicare and/or Texas 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 D5 How to change health plans

You can change your health plan. For more information, refer to Chapter 10, Section A. You can also get help from the following resources:

- Call MAXIMUS at **1-703-712-4000**, 8 a.m.–6 p.m. local time, Monday–Friday. TTY users should call **711**.
- Call the State Health Insurance Assistance Program (SHIP) at **1-800-252-3439**.
- 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**.

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

Long Term Services and Supports (LTSS) are services by health care providers who offer direct in-home and community based services for elderly people and people with disabilities. Call Member Services **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F to ask about these services.

What are some of my long term services and supports (LTSS) benefits?

- Adaptive aids such as wheelchairs, walkers, canes, and durable medical equipment.
- Adjunct services.
- Adult foster home services.

- Assisted living/residential care services.
- Member managed attendant care (Consumer Directed Services).
- Day activity and health services.
- Emergency response services
- Home health care services.
- Home delivered meals.
- Medical supplies.
- Minor home modifications — to ensure accessibility and improve mobility.
- Nursing services.
- Nursing facility care.
- Personal assistance services.
- Respite care.
- Sub-acute care.
- Supported and employment assistance.
- Therapy services to include cognitive, occupational, physical and speech/language therapy.

How do I get these services? What number do I call to find out about these services?

Call your UnitedHealthcare Connected® Service Coordinator at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

Section F How to get behavioral health services

UnitedHealthcare Connected® covers medically necessary behavioral health services. If you have a drug problem or are very upset about something, you can get help. Call **1-877-604-0564** for help. You do not need a referral for these services.

There will be people who can speak with you in English or Spanish. If you need help with other languages, please tell them. Member Services will connect you to the Language Line and answer your questions. Please call TTY **711**, for hearing impaired.

If it is a crisis and you have trouble with the phone line, call **911** or go to the nearest emergency room and call UnitedHealthcare Connected® within 24 hours.

Section G How to get self-directed care

Section G1 What self-directed care is

A program for people with attendant/provider services called Consumer Directed Services (CDS). It allows you more control over your program services if you're able and willing to take more responsibility for coordinating the services. With this program, you find, hire and train your attendant/provider. You also review the budget for the services. You decide how much to pay your attendant. You decide how much to spend for the supplies and equipment you need. You can pick the person to handle the services for you. If you pick this program, an agency will teach you what to do. The agency will also handle the payroll for your services.

If you pick the CDS choice, you are the employer. You can hire, fire and manage your own health service providers. This can include your attendant(s), back-up attendant(s), in-home and out-of-home respite providers and habilitation providers. You have control over how your program funds are spent on salary and benefits for your employee(s).

Section G2 Who can get self-directed care

People who are receiving attendant/provider services.

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

You will be to pick a Financial Management Services Agency (FMSA). The agency will train you on the hiring process, including documents and forms to be completed for new employees; show you how to manage timesheets, due dates, payday schedules, and disbursing employee payroll checks. The agency will act as your bookkeeper and banker, taking care of payroll and the government forms on behalf of the CDS employer. The agency works with you on your budget, but does not control it. You decide how the money is spent on salary and benefits for your employee(s) within the guidelines. You also have the right to name a designated representative (DR) to assist you with the employer duties. The DR is not your employee, and is not paid; a DR is a willing adult you choose to provide you with help when you need it. You decide which employer tasks your DR will help you with or conduct.

Call your UnitedHealthcare Connected® Service Coordinator to help you make the best choice. They can tell you what services you can get. Call **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

Section H How to get Nonemergency Medical Transportation (NEMT) Services

Please refer to Chapter 4 for more information about benefit limitations.

Section H1 What NEMT Services are

Medical transport is provided for covered health care services if you have no other way to get to the doctor, live in an area with no public transport or cannot use public transport due to a health condition or disability.

- These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get health care services.
- These trips do not include ambulance trips.

Call our Transportation Services at **1-866-427-6607**, TTY **1-866-288-3133**. Your ride will be comfortable and safe.

Section H2 What services are included

NEMT Services include:

- Passes or tickets for transportation, such as mass transit within and between cities or states (including by rail or bus).
- Commercial airline transportation services.
- Demand response (curb-to-curb) transportation services in private buses, vans, or sedans (including wheelchair-accessible vehicles, if necessary).
- Mileage reimbursement for an enrolled individual transportation participant (ITP) for a verified completed trip to a covered health care service. The enrolled ITP can be you, a responsible party, family member, friend or neighbor. If you're interested in becoming an enrolled ITP please contact **1-866-427-6607**, TTY **1-866-288-3133** to discuss your need.
- Transportation costs for your NEMT attendant if you need them to travel to your appointment with you. An NEMT attendant is:
- An adult providing necessary mobility or personal or language assistance to you during transportation. (For example, this can include an adult serving as your personal attendant.)
- A service animal providing necessary mobility or personal assistance to you during transportation and that occupies a seat that would otherwise be filled by another person.
- An adult traveling with you because a health care provider has stated in writing that you require an attendant.

Section H3 How to schedule NEMT Services

Remember to schedule rides as early as possible, and **at least two business days before you need the ride**. You can request a ride with less than 48 hours notice in certain cases, including:

- Pickup after a hospital discharge.
- Trips to the pharmacy for medication or approved medical supplies.
- Dental needs
- Trips for urgent conditions. (An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.)

Schedule rides for long-distance trips at least five days in advance.

The least costly means of transportation that is appropriate for your medical need must be used. Rides can be scheduled up to 30 days in advance.

They will ask you for:

- Your ID number
- Your first and last name
- The address of the location you are visiting
- Your appointment time and location
- Your date of birth

Tell them if you need a wheelchair lift, if you have an attendant and/or a service animal.

When it is time for your ride:

- The day before your ride, you may receive a phone call or text message that reminds you of the appointment. The message provides the details of the trip including the name of the company that will pick you up.
- You may call **1-866-427-6608**, TTY **1-866-288-3133** to get details of the trip including the name of the company that will pick you up.

Call 1-866-427-6608, TTY 1-866-288-3133 if:

- Your ride is late
- The ride home has not been scheduled for a specific time and you are ready to go home.
- You have an after-hours request.
- Your medical appointment is canceled or changed

If you have a scheduled ride and your health care appointment is cancelled **before** the trip, contact Transportation Services at **1-866-427-6607**, TTY **1-866-288-3133**, 8:00 a.m.–5:00 p.m., M–F right away.

Members birth through age 14 must be accompanied by a parent, guardian, or other authorized adult.

Members birth through age 20 may be eligible for advanced funds or meals and lodging for authorized medical travel. The daily rate for meals is $25 per day, per person. Lodging services are limited to the overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.

Members age 15–17 years old must be accompanied by a parent, or guardian, or other authorized adult or have consent from a parent, or guardian, or other authorized adults on file to travel alone. Parental consent is not required if the health care service is confidential in nature. Call **1-866-427-6607**, TTY **1-866-288-3133**, 8:00 a.m.–5:00 p.m., M–F to discuss your need.

If you have a complaint about the transportation service, call Member Services at **1-800-256-6533** TTY **711**.

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 to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when
  - there is not enough time to safely transfer you to another hospital before delivery.
  - a transfer to another hospital may pose a threat to your health or safety or that of your unborn child.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call **911** or use the nearest emergency room or hospital. Call for an ambulance if you need it. You 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 from any provider with an appropriate state license.

- **Tell UnitedHealthcare Connected® about your emergency as soon as possible.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours using the number on the back of your Member ID Card. Also, if the hospital has you stay, please make sure we are called within 48 hours using the phone number on the back of your Member ID Card. However, you will not have to pay for emergency services because of a delay in telling us.

Covered services in a medical emergency

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. 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. Neither Medicare nor Texas Medicaid pays for emergency medical care 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.

Definition of post-stabilization

Post-stabilization care services are services that keep your condition stable following emergency medical care.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. 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 an emergency

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.

If you do not know whether you need to go to an urgent care center, you can call your PCP or our 24 hours a day/7 days a week NurseLine service at **1-844-222-7323** (TTY **711**) and your PCP or NurseLine Representative will help you. Don't forget to tell your PCP about any visits to an urgent care center. By doing this, your PCP can help coordinate your health care.

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.

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 Connected®.

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

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

If you believe that you should be paid back for Texas Medicaid-covered benefits that you already paid for, please call Member Services for help.

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 to learn what to do.

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

If you believe that you should be reimbursed for Texas Medicaid-covered benefits that you already paid for, please call Member Services for help.

UnitedHealthcare Connected® covers all services:

- that are medically necessary, **and**
- that are listed in the plan's Benefits Chart (refer to Chapter 4), **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 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.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. 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.

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 Service 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.

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.
  - Inpatient Hospital coverage limits are the same as what is 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 for use 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 Connected®, you usually will not own DME, no matter how long you rent it.

In certain 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.

Our plan will pay for some durable medical equipment (DME) and products normally found in a pharmacy. UnitedHealthcare Connected® pays for nebulizers, ostomy supplies, and other

covered supplies and equipment if they are medically necessary. Call Member Services for more information about these benefits.

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

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/**) 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 Medicare Advantage

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 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 a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your 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 Connected® covers and any restrictions or limits on those services and how much you pay for each service. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

Table of Contents

Section A Your covered services and your out-of-pocket costs

This chapter tells you what services UnitedHealthcare Connected® pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5. This chapter also explains limits on some services.

Because you get assistance from Texas Medicaid, you pay nothing for your covered services as long as you follow the plan's rules. Refer to Chapter 3 for details about the plan's rules.

If you need help understanding what services are covered, call your Service Coordinator and/or Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

Section A1 During public health emergencies

During a declared public health emergency (e.g., the COVID-19 pandemic), if you get medically-necessary services from an out-of-network provider at any time during the public health emergency, please call us to help you obtain reimbursement for any out of pocket expense you might have incurred. Please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

Section B Rules against providers charging you for services

We do not allow UnitedHealthcare Connected® 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 or call Member Services.

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 service listed in the Benefits Chart, as long as you meet the coverage requirements described below.

- Your Medicare and Texas Medicaid covered services must be provided according to the rules set by Medicare and Texas Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be

medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.

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

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

- Some medical practices and treatments are not yet proven to be effective. New practices, treatments, tests and technologies are reviewed nationally by UnitedHealthcare Community Plan to make decisions about new medical practices and treatments and what conditions they can be used for. This information is reviewed by a committee of UnitedHealthcare Community Plan doctors, nurses, pharmacists and guest experts who make the final decision about coverage. If you would like more information about how we make decisions about new medical practices and treatments, call us at **1-800-256-6533**, TTY **711**.
- UnitedHealthcare reviews new procedures, devices and drugs to decide if they are safe and effective for members. If they are found to be safe and effective, they may become covered. If new technology becomes a covered service, it will follow plan rules, including medical necessity.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 has more information about using network and out-of-network providers.
- You can get services included here by calling your primary care provider or network specialist directly or your Service Coordinator.
- You have a primary care provider (PCP) or a care team that is providing and managing your care.
- 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 in italic type.

Benefits and limits as described in the Texas Medicaid Provider Procedures Manual unless otherwise noted.

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

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.	$0
Acupuncture for chronic low back pain 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 each year. Acupuncture treatments must be stopped if you don't get better or if you get worse.	$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. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.	$0

Services that our plan pays for	What you must pay
Ambulance services Covered ambulance services include fixed-wing, rotary-wing, 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
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
Behavioral health services The plan will pay for the below services for individuals living with severe, persistent mental illness (defined as diagnoses of schizophrenia, bipolar disorder, schizoaffective disorder, and major depression) • Mental health targeted case management • Mental health psychosocial rehabilitative services	$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

Services that our plan pays for	What you must pay
Breast cancer screening (mammograms) The plan will pay for the following services: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	$0
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	$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.	$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 within the last 3 years and are of childbearing age: one Pap test every 12 months	$0
Chiropractic services The plan will pay for the following services: • Adjustments of the spine to correct alignment	$0
Cologuard • Coverage begins at age 45 and frequency of coverage is the same as Medicare.	$0
Colorectal cancer screening For people 50 and older, 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 • Outpatient diagnostic colonoscopy 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).	$0

Services that our plan pays for	What you must pay
Counseling to stop smoking or tobacco use If you use tobacco but do not have signs or symptoms of tobacco-related disease: • The plan will pay for two counseling quit attempts 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 counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.	$0
Cytogenomic Constitutional Microarray • Covered for for women who undergo prenatal diagnostic procedures, and products of conception resulting from recurrent miscarriage. • Exceptions to the one-per-lifetime limitation will be made with documentation of medical necessity (e.g., subsequent pregnancies).	$0
Dental services UnitedHealthcare Connected® will pay for the following services: Eligible members ages 21 and older may receive all dental services up to $1,000 per year benefit to cover one routine exam and cleaning per year, full mouth x-ray, dentures and denture repair, medically necessary scaling and root planing (non-waiver members only). If you are a waiver member, please see the “community-based services” section later in this Chapter.	$0
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.	$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.	$0

Services that our plan pays for	What you must pay
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: – A blood glucose monitor – Blood glucose test strips – Lancet devices and lancets – Glucose control solutions for checking the accuracy of test strips and monitors. UnitedHealthcare Connected® covers any blood glucose monitors and test strips specified within the list to the right. We will generally not cover alternate brands unless your doctor or other provider tells us that use of an alternate brand is medically necessary in your specific situation. If you are new to our plan and are using a brand of blood glucose monitors and test strips that are not on our list, you may contact us within the first 90 days of enrollment into the plan to request a temporary supply of the alternate brand while you consult with your doctor or other provider. During this time, you should talk with your doctor to decide whether any of the preferred brands are medically appropriate for you.	$0 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. *Your provider may need to obtain prior authorization*. $0 copayment for each Medicare-covered Continuous Glucose Monitor and supplies in accordance with Medicare guidelines. There are no brand limitations for Continuous Glucose Monitors. *Your provider may need to obtain prior authorization*.

Services that our plan pays for	What you must pay
Diabetic self-management training, services, and supplies (continued) • If you or your doctor believes it is medically necessary for you to maintain use of an alternate brand, you may request a coverage exception to have us maintain coverage of a non-preferred product through the end of the benefit year. Non-preferred products will not be covered following the initial 90 days of the benefit year without an approved coverage exception. • If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).) • 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** – Diabetic Insoles. Eligible diabetic Members may request to receive two pair of full-length foot insoles. Eligible for MMP Members ages 18 and older. Two pair of foot insoles offered each calendar year. Member must reside in Community. Excludes bedbound individuals. 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. Limited to 20 visits of 30 minutes per year for a max of 10 hours the initial year. Follow-up training subsequent years after, limited to 4 visits of 30 minutes for a max of 2 hours per year.	

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 as well as Chapter 3, Section M of this handbook.) The following items are covered: • 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 • Walkers Other items may be covered. We will pay for all medically necessary DME that Medicare and Texas 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. Benefits and limits as described in the Texas Medicaid Provider Procedures Manual. Includes disposable medical supplies. *Prior authorization may be needed*.	$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 to that of your unborn child; **or** • serious harm to bodily functions; **or** • serious dysfunction of any bodily organ or part; **or** • in the case of a pregnant woman in active labor, when: – there is not enough time to safely transfer you to another hospital before delivery. – a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. Medical services performed out of the country are not covered.	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay. Please call us right away if you are admitted.

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. 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 (birth control pills, patch, ring, IUD, injections, implants) • Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • Counseling and diagnosis of infertility, and related services • Counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions • Treatment for sexually transmitted infections (STIs) • 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 use a provider in the plan's network for the following services: • Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • Treatment for AIDS and other HIV-related conditions • Genetic testing You have access to freestanding birthing centers.	$0

Services that our plan pays for	What you must pay
Health and wellness education programs **Health Education programs.** • Adult Activity Books with prepaid postage post cards - Eligible Members may receive adult activity books: word search, crossword puzzle, Sudoku, coloring book, and prepaid postage post cards. Member will also receive a pack of colored pencils. • You can get a hypoallergenic mattress cover and pillowcase per year if you are diagnosed with Chronic Obstructive Pulmonary Disease (COPD) or asthma. Members should be under active case management and live in the Community. • Toll-free access to registered nurses, including Spanish-speaking nurses, 24 hours a day, 365 days a year. • Members and caregivers will have access to FindHelp.org, a web-based social care network that connects members to free or reduced-cost community resources and need-based social services to proactively address member Social Determinants of Health. • Members and caregivers will have access to **LiveandWorkWell.com**. This is a confidential resource from Optum.® • We also help you get specific counseling services for adults 21 and over (up to 30 visits per year). • Telemedicine, telehealth, and tele-monitoring services, web/phone-based technology, and enhanced Disease Management. – Intensive service coordination and disease management (DM), both education intensive and member focused, for members including, but not limited to, those with the following diagnoses: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) and members with complex chronic or co-morbid conditions and that are considered to be high risk.	$0

Services that our plan pays for	What you must pay
Health and wellness education programs (continued) • Herb Garden Kits with recipes — One herb garden kit with recipe cards for members who are interested in improving their health through healthier home cooking. • Exercise Kit — One pedometer, one pack of resistance bands, and one water bottle for members who are interested in losing weight or adopting an active lifestyle. • Pill organizer with health tracker booklet — One pill organizer and health tracker booklet per fiscal year. This will allow for members to independently manage their medications and track their health. Your Service Coordinator can tell you more about our counseling and Disease Management services. *Prior authorization may be needed — please talk to your PCP or Service Coordinator.*	
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. The plan will also pay for one hearing aid for one ear every five years from the month it is dispensed, either the left or the right may be reimbursed but not both in the same five year period. Prior authorization may be needed — please talk to your PCP or Service Coordinator.	$0
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. For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.	$0

Services that our plan pays for	What you must pay
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. 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 *Prior authorization is needed — please talk to your Service Coordinator.* New mothers can get two home health visits without a doctor's order or prior authorization.	$0

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 prognosis 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 B are billed to Medicare.** • Refer to Section F of this chapter for more information. **For services covered by UnitedHealthcare Connected® but not covered by Medicare Part A or B:** • UnitedHealthcare Connected® will cover plan-covered services not covered under Medicare Part A or 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 UnitedHealthcare Connected® for 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. **Note:** If you need non-hospice care, you should call your Service Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Please call your Service Coordinator directly or call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. Our plan covers hospice consultation services for a terminally ill person who has not chosen the hospice benefit.	$0

Services that our plan pays for	What you must pay
Immunizations The plan will pay for the following services: • Pneumonia vaccine • Flu vaccine, once each flu season in the fall and winter, with additional flu vaccine 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 or Medicaid coverage rules The plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 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 abuse services • Blood, including storage and administration – The plan will pay for whole blood and packed red cells beginning with the fourth pint of blood you need. You must pay for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. – The plan will pay for all other parts of blood beginning with the first pint used. • Physician services • Post discharge home delivered meals for members returning to the Community from a hospital stay or Nursing Facility.	$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. We cover an additional 30 calendar days after your Medicare-covered days are used. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. This is called an “Outpatient Observation” stay. If you are not sure if you are an inpatient or outpatient, you should ask your doctor or the hospital staff.

Services that our plan pays for	What you must pay
Inpatient hospital care (continued) • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. 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. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If UnitedHealthcare Connected® provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person. Please talk to your Service Coordinator or PCP. Benefits and limits as described in the Texas Medicaid Provider Procedures Manual. For example, 30-day spell of illness applies. *Prior authorization is needed. A referral may be needed.*	
Inpatient services in a psychiatric hospital • The plan will pay for mental health care services that require a hospital stay. Benefit is not covered for individuals between the ages of 22 and 64 consistent with the federal provision on institutions of mental disease. The MCO may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting. The MCO may provide substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting. *Prior authorization is needed.*	$0

Services that our plan pays for	What you must pay
Inpatient stay: Covered services in a hospital during a non-covered inpatient stay If your inpatient stay is not reasonable and necessary, the plan will not pay for it. However, in some cases the plan will pay for services you get while you are in the hospital. The plan will pay for the following services, and maybe other services not listed here: • Doctor services • Diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • Surgical dressings • Splints, casts, and other devices used for fractures and dislocations • Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: – replace all or part of an internal body organ (including contiguous tissue), **or** – replace all or part of the function of an inoperative or malfunctioning internal body organ. • Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient's condition • Physical therapy, speech therapy, and occupational therapy	$0

Services that our plan pays for	What you must pay
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, 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" below this chart.	$0
Lung cancer screening The plan will pay for lung cancer screening every 12 months if you: • Are aged 50–77, **and** • Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • Have smoked at least 1 pack a day for 30 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

Services that our plan pays for	What you must pay
Meal benefit Meal Support for Eligible non-Waiver members in the Community recently discharged from the hospital or skilled nursing facility (Immediately following surgery or inpatient hospitilization). Up to 12 home-delivered meals for two weeks, with maximum of 24 meals for four weeks (28 days), each year after getting out of hospital or nursing facility or when a doctor asks as part of a supervised program to ease the effects of a chronic illness.	$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.	$0
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 Part B of Medicare. UnitedHealthcare Connected® will pay for the following drugs that may be subject to step therapy: • Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center 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 agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases • Chemotherapy Drugs, and the Administration of chemotherapy drugs The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: **https://medicare.uhc.com/medicare/member/documents/part-b-step-therapy.html**	$0

Services that our plan pays for	What you must pay
Medicare Part B prescription drugs (continued) You or your doctor may need to provide more information about how a Medicare Part B prescription drug is used in order to determine coverage. There may be effective, lower-cost drugs that treat the same medical condition. If you are prescribed a new Part B medication or have not recently filled the medication under Part B, you may be required to try one or more of these other drugs before the plan will cover your drug. If you have already tried other drugs or your doctor thinks they are not right for you, You or your doctor can ask the plan to cover the Part B drug. (For more information, see Chapter 9, What to do if you have a problem or complaint (coverage decisions, appeals, complaints). Please contact Member Services for more information. Chapter 5 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6 explains what you pay for your outpatient prescription drugs through our plan. *Prior authorization may be needed — please talk to your PCP or Service Coordinator*	

Services that our plan pays for	What you must pay
Nonemergency Medical Transportation (NEMT) services (Help Getting a Ride) The plan will pay for transportation services to nonemergency health care appointments if you have no other transportation options. • These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get health care services. • These trips do not include ambulance trips. NEMT services include: • Passes or tickets for transportation, such as mass transit within and between cities or states (including by rail or bus). • Commercial airline transportation services. • Demand response (curb-to-curb) transportation services in private buses, vans, or sedans (including wheelchair-accessible vehicles, if necessary). • Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor. Transportation for members to be able to access value add services (VAS) that require transportation and for members who do not receive NEMT. For example, visits to providers that do not have a TPI, VAS therapy providers not covered by the NEMT benefit, and UHC member events/MAC meetings as approved by UnitedHealthcare Community Plan Case Managers or Member Advocates. Limited to twelve (12) one-way trips per year. Reservations are required. Please call **1-866-427-6607**, TTY **1-866-288-3133**, 8:00 a.m.–5:00 p.m., Monday–Friday. Call at least 2 business days before your appointment.	$0

Services that our plan pays for	What you must pay
Nursing facility care Covered for basic health services (acute care) (either through Medicare or STAR+PLUS) and long-term care services through STAR+PLUS. One welcome kit for members each year when you are admitted to a network nursing home. At a minimum each kit includes: • Gripper socks • Shower cap • Water bottle/Coffee cup • Lighted magnifier • Reusable bag • Night Light Post discharge home delivered meals for members returning to the Community from a hospital stay or Nursing Facility. The nursing facility is responsible for providing transportation to medical services outside the facility. NEMT Services are available to members in a nursing facility for transportation to dialysis treatment centers. Waterproof Clothing Labels — One pack (100) of preprinted member name waterproof clothing labels for members in a nursing facility to keep their clothes/items from getting lost. Bonsai Kit — Bonsai kit available for members in a nursing facility (as allowed) for stress relief and cognitive engagement. Exercise Kit — One pedometer, one pack of resistance bands, and one water bottle for members who are interested in losing weight or adopting an active lifestyle.	$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.	$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 or chemicals in your body (toxicology testing)	There is no coinsurance, copayment, or deductible. Additional coverage may be available based on the Medicaid portion of the plan's coverage.
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 fourth pint of blood that you need. You must pay for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. The plan will pay for storage and administration beginning with the first pint of blood you need. • Other outpatient diagnostic tests *Prior authorization may be needed — please talk to your PCP or Service Coordinator.*	$0

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 *Prior authorization may be needed — please talk to your PCP or Service Coordinator*	$0

Services that our plan pays for	What you must pay
Outpatient mental health care The plan will pay for mental health services provided by: • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical nurse specialist, • a nurse practitioner, • a physician assistant, **or** • 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: • Clinic services • Day treatment • Psychosocial rehab services	$0
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. *Prior authorization is needed — please talk to your Service Coordinator.*	$0
Outpatient substance abuse services Outpatient treatment and counseling for substance abuse.	$0
Outpatient surgery The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. *Prior authorization may be needed — please talk to your PCP.*	$0

Services that our plan pays for	What you must pay
Partial hospitalization services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service. 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
Personal assistance services The plan covers personal assistance with activities of daily living. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Grooming • Eating • Bathing • Dressing and personal hygiene • Functional living tasks / assistance with planning • Preparing meals • Transportation, or assistance in securing transportation • Assistance with ambulation and mobility • Reinforcement of behavioral support or specialized therapies activities; **and** • Assistance with medications These services can be self-directed if you choose. This option allows you or your legally authorized representative to be the employer of some of your service providers and to direct the delivery of program services. *Prior authorization is needed — please talk to your Service Coordinator.*	$0
Personal Emergency Response System (PERS) The plan covers emergency response services for you through an electronic monitoring system 24 hours a day, seven days a week. In an emergency, you can press a call button to signal for help. *Prior authorization is needed — please talk to your Service Coordinator.*	$0 Benefits and limits as described in the Texas Medicaid Provider and Procedures Manual, as required by CFC.

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 – hospital outpatient department • Consultation, diagnosis, and treatment by a specialist *Prior authorization may be needed — please talk to your PCP or Service Coordinator* • Telehealth services for members with a substance use disorder or co-occurring mental health disorder • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: – You have an in-person visit within 6 months prior to your first telehealth visit – You have an in-person visit every 12 months while receiving these telehealth services – Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke	$0

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: – you're not a new patient **and** – the check-in isn't related to an office visit in the past 7 days **and** – the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if: – you're not a new patient **and** – the evaluation isn't related to an office visit in the past 7 days **and** – the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Basic hearing and balance exams given by your primary care provider or specialist, if your doctor orders them to see whether you need treatment • Second opinion by another network provider before a 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.	
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 with conditions affecting the legs, such as diabetes	$0

Services that our plan pays for	What you must pay
Prostate cancer screening exams For men age 50 and older, the plan will pay for the following services once every 12 months: • A digital rectal exam • A prostate specific antigen (PSA) test	$0
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) 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. The plan will not pay for prosthetic dental devices for non-waiver members. If you are on a STAR+PLUS waiver program this may be covered with approval. *Prior authorization may be needed — please talk to your PCP or Service Coordinator.*	$0
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

Services that our plan pays for	What you must pay
Sexually transmitted infections (STIs) screening and counseling The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. 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 STIs. 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

Services that our plan pays for	What you must pay
Skilled nursing facility (SNF) care No prior hospital stay is required. 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 fourth pint of blood you need. You must pay for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. – The plan will pay for all other parts of blood beginning with the first pint used. • 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	$0 Benefits and limits as described in the Texas Medicaid Provider and Procedures Manual.

Services that our plan pays for	What you must pay
Skilled nursing facility (SNF) care (continued) 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 *Notification is needed — please talk to your PCP or Service Coordinator.*	
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
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). Medical services performed out of the country are not covered.	$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. Medicare does not cover regular eye exams for glasses or contacts. 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 who are age 50 and older, **and** • Hispanic Americans who are 65 or older. The plan covers one eye exam every two years. The plan will pay for one pair of glasses or contact lenses every two years. The plan will also pay for standard corrective lenses, and frames, and replacements if you need them after a cataract removal without a lens implant. Eligible Members ages 21 and older. Must use in-network provider. Up to $105 maximum benefit 24 months, aligning with Medicaid benefit, to cover upgrades for frames, lenses, contact lenses, or for loss or damage that are not covered by the Medicaid benefit. The benefit period is measured from the date of service. Cannot be used for a second or spare pair. Please talk to your Service Coordinator to learn more. *Prior authorization may be needed — please talk to your PCP or Service Coordinator.*	$0

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

Section E Our home and community based services

In addition to these general services, our plan also covers home and community-based services. These are services that you may be able to use instead of going to a facility. To get some of these services, you will need to qualify for the home and community-based waiver (the STAR+PLUS Waiver). Your Service Coordinator will work with you to decide if these services are right for you and will be in your Plan of Care.

Community-based services that our plan covers	What you must pay
Adaptive aids and medical supplies The plan covers the following devices, controls, appliances, or items that are necessary to address your specific needs, including those necessary for life support up to a $10,000 per year limit. The plan may pay for the following if medically or functionally necessary, and maybe other items/services not listed here: • Lifts, including vehicle lifts • Mobility Aids • Positioning Devices • Control switches/pneumatic switches and devices • Environmental control units • Medically necessary supplies • Communication aids (including batteries) • Adaptive/modified equipment for activities of daily living • Safety restraints and safety devices Service Coordinators can help you get medical supplies or equipment. You must be on the STAR+PLUS waiver program for this service/benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0

Community-based services that our plan covers	What you must pay
Adult foster care The plan covers 24-hour living arrangements in a foster home if you have physical, mental, or emotional limitations or if you are unable to continue functioning independently in your own home. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Meal preparation • Housekeeping • Personal care • Nursing tasks • Supervision • Companion services • Daily living assistance • Transportation You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed — please talk to your Service Coordinator.*	$0

Community-based services that our plan covers	What you must pay
Assisted living services The plan covers a 24-hour living arrangement for you if you are unable to live independently in your own home. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Host home/companion care that provides you with: – Personal assistance – Functional living tasks – Supervision of your safety and security – Habilitation activities • Supervised living that provides you with: – Personal assistance – Functional living tasks – Supervision of your safety and security – Habilitation activities • Residential support service that provides you with: – Personal assistance – Functional living tasks You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0
Behavioral health care services These services include mental health targeted case management and mental health rehabilitative services. Institution for Mental Disease Services for Individuals 65 or Older: Authorization must be obtained from a designated behavioral health vendor.	$0

Community-based services that our plan covers	What you must pay
Cognitive rehabilitation therapy The plan covers services that help you learn or re-learn cognitive skills. These skills may have been lost or altered as a result of damage to brain cells or brain chemistry. You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0
Day activity and health services These services are provided at a Day Activity and Health Services facility which include nursing and personal care services, physical rehabilitative services, nutrition services, transportation services and other supportive services.	$0
Habilitation services These services help you with obtaining, retaining, or improving skills necessary to live successfully at home and/or in community-based settings. They promote independence, personal choice, and achievement of the outcomes identified in your service plan. You must meet institutional level of care requirements. Please talk to your Service Coordinator. *Prior authorization is needed.*	$0

Community-based services that our plan covers	What you must pay
Dental services The plan covers the following services to help preserve your teeth and meet your medical needs up to $5,000 per year. If the services of an oral surgeon are required, you can get an additional $5,000 per year if you ask. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Emergency dental treatment • Preventive dental treatment • Therapeutic dental treatment (restoration, maintenance, etc.) • Orthodontic dental treatment You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed — please talk to your Service Coordinator.*	$0
Emergency response services The plan covers emergency response services for you through an electronic monitoring system 24 hours a day, 7 days a week. In an emergency, you can press a call button to signal for help. You must meet institutional level of care requirements. Please talk to your Service Coordinator.	$0

Community-based services that our plan covers	What you must pay
Employment assistance The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Identifying your employment preferences, job skills, and requirements for a work setting and work conditions • Locating prospective employers offering employment compatible with your identified preferences, skills, and requirements; • Contacting a prospective employer on your behalf and negotiating your employment • Transportation • Participating in service planning team meetings You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0
Functional living task services These services help you with: • Planning and preparing meals • Transportation, or help in securing transportation • Assistance with ambulation and mobility • Reinforcement of behavioral support or specialized therapies activities • Assistance with medications	$0
Home-delivered meals The plan covers hot, nutritious meals that are served in your home. Meals are limited to 1 to 2 per day. You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0

Community-based services that our plan covers	What you must pay
Minor home modifications The plan covers minor home modifications to ensure your health, welfare, and safety and to allow you to function with greater independence in your home. The plan will cover up to $7,500 over the course of your lifetime and will also cover up to $300 each year for repairs. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Installation of ramps and grab bars • Widening of doorways • Modifications of kitchen and bathroom facilities, and • Other specialized accessibility adaptations You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed — please talk to your Service Coordinator.*	$0
Nursing services The plan covers the treatment and monitoring of your medical conditions, especially if you have chronic conditions that require specific nursing tasks. You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0

Community-based services that our plan covers	What you must pay
Occupational therapy The plan covers occupational therapy for you, which provides assessment and treatment by a licensed occupational therapist. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Screening and assessment • Development of therapeutic treatment plans • Direct therapeutic intervention • Assistance, and training with adaptive aids and augmentative communication devices • Consulting with and training other service providers and family members • Participating on the service planning team, when appropriate You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0
Oximeter with health tracker booklet Oximeter with Health Tracker Booklet Eligible members who do not qualify for the oximeter DME and who are under active case management will receive one finger pulse oximeter, two reusable cloth face masks, and a health tracker booklet. This will be sent directly to the qualifying member from the UnitedHealthcare Connected® (Medicare-Medicaid Plan).	$0

Community-based services that our plan covers	What you must pay
Personal assistance services The plan covers personal assistance with activities of daily living. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Grooming • Eating • Bathing • Dressing and personal hygiene • Functional living tasks / assistance with planning • Preparing meals • Transportation or assistance in securing transportation • Assistance with ambulation and mobility • Reinforcement of behavioral support or specialized therapies activities; **and** • Assistance with medications *Prior authorization is needed — please talk to your Service Coordinator.*	$0
Pest control: Pest Control One 6-pack of roach repellant wall plugins for eligible members who are under active case management with a diagnosis of asthma or COPD. This will be sent directly to the qualifying member from the UnitedHealthcare Connected® (Medicare-Medicaid Plan).	$0

Community-based services that our plan covers	What you must pay
Physical therapy The plan covers physical therapy, assessments, and treatments by a licensed physical therapist. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Screening and assessment • Development of therapeutic treatment plans • Direct therapeutic intervention • Assistance and training with adaptive aids/augmentative communication devices • Consulting with and training other service providers and family members • Participating on the service planning team, when appropriate You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed — please talk to your Service Coordinator.*	$0

Community-based services that our plan covers	What you must pay
Respite care The plan may pay for the following services if medically or functionally necessary up to 30 days a year, and maybe other services not listed here: • Personal assistance • Habilitation activities • Community activities • Leisure activities • Supervision of your safety and security • Development of socially valued behaviors • Development of daily living skills Respite care is provided to ensure your comfort, health, and safety. It may be provided in the following locations: your home or place of residence; adult foster care home; Texas Medicaid certified nursing facility; and an assisted living facility. You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0

Community-based services that our plan covers	What you must pay
Speech, hearing, and language therapy The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Screening and assessment • Development of therapeutic treatment plans • Direct therapeutic intervention • Assistance/training with adaptive aids and augmentative communication devices • Consulting with and training other service providers and family members • Participating on the service planning team, when appropriate You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0
Support consultation When requested, you have access to optional support consultation provided by a chosen certified support advisor. This advisor will assist you in learning about and performing employer responsibilities. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Recruiting, screening, and hiring workers • Preparing job descriptions • Verifying employment eligibility and qualifications, and other documents required to employ an individual • Managing workers • Other professional skills as needed You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0

Community-based services that our plan covers	What you must pay
Supported employment The plan covers supported employment, which is provided to you at your place of employment if: • You need the support services to maintain employment due to a disability; • You are paid minimum wage (or more) for the work performed; **and** • Your place of employment is competitive and integrated. The plan also covers transportation to and from your worksite, and supervision and training to you beyond what an employer would ordinarily provide. You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0

Community-based services that our plan covers	What you must pay
Transitional assistance services The plan covers one transition from a nursing facility to a home in the community, up to a $2,500 limit. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Payment of security deposits required to lease an apartment or home • Set-up fees or deposits to establish utility services for the home, including telephone, electricity, gas, and water • Purchase of essential furnishings for the apartment or home, including table, chairs, window blinds, eating utensils, food preparation items, and bath linens • Payment of moving expenses required to move into or occupy the home or apartment; and • Payment for services to ensure your health in the apartment or home, such as pest eradication, allergen control, or a one-time cleaning before occupancy You must be on the STAR+PLUS waiver program for this service/ benefit. *Prior authorization is needed – please talk to your Service Coordinator.*	$0

Section F Benefits covered outside of UnitedHealthcare Connected®

The following services are not covered by UnitedHealthcare Connected® but are available to you through Medicare or Texas Medicaid.

Section F1 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. Hospice programs provide members

and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement. 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 Connected® pays for while you are getting hospice care services.

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

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services and any Medicare Part A or B services. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis *(except for emergency care or urgently needed care):*

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

For drugs that may be covered by UnitedHealthcare Connected®'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.

Note: If you need non-hospice care, you should call your Service Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Your Service Coordinator can be reached at the phone number in Chapter 2 or you can call Member Services at the phone number on the bottom of this page.

Section F2 Pre-Admission Screening and Resident Review (PASRR)

This is a program to ensure members are not inappropriately placed in nursing homes. This requires that members (1) be evaluated for mental illness, intellectual disability, or both; (2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (3) get the services they need in those settings.

Section G Benefits not covered by UnitedHealthcare Connected®, Medicare, or Texas 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 Texas 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.

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

1. Services considered not "reasonable and necessary," according to the standards of Medicare and Texas Medicaid, unless these services are listed by our plan as covered services.
2. 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, page 43 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
3. Surgical treatment for morbid obesity, except when it is medically necessary.
4. A private room in a hospital, except when it is medically necessary.
5. Private duty nurses. If you are on a STAR+PLUS waiver program this may be covered with approval.
6. Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
7. Full-time nursing care in your home. If you are on a STAR+PLUS waiver program this may be covered with approval.
8. Fees charged by your immediate relatives or members of your household.
9. Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
10. 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.
11. Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
12. Routine foot care, except for the limited coverage provided according to Medicare guidelines.
13. Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease for non-waiver members. If you are on a STAR+PLUS waiver program this may be covered with approval.

14. Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease for non-waiver members. If you are on a STAR+PLUS waiver program this may be covered with approval.
15. Radial keratotomy, LASIK surgery, and other low-vision aids.
16. Reversal of sterilization procedures, sex change operations, penile prostheses, and non-prescription contraceptive supplies.
17. Naturopath services (the use of natural or alternative treatments).
18. 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. Members are still responsible for their cost sharing amounts.
19. Immunizations for foreign travel purposes.

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 some prescription and over-the-counter drugs covered under Texas Medicaid. Chapter 6 tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

UnitedHealthcare Connected® 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, certain home health supply products (test strips, lancets, spacers) 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.

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. You generally must use a network pharmacy to fill your prescription.
4. 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 Chapter 9 to learn about asking for an exception.
5. 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 (FDA) or supported by certain medical references.

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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.

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 our share of the cost of your covered prescription drug. You may need to pay the pharmacy a copay when you pick up your prescription.

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.

In some cases, **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 for our share. 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.
- If you need help getting a prescription filled, you can contact Member Services.

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

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

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

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.

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.

Section A6 Using mail-order services to get your drugs

Our plan's mail-order service allows you to order up to a 90-day supply. A 31-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, contact our mail service pharmacy, OptumRx. OptumRx can be reached at **1-877-889-6358**, or for the hearing impaired, (TTY) **711**, 24 hours a day, 7 days a week.

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 drug store, go to your drug store to fill the prescription. If your delayed prescription is not on file at your local drug store, then please ask your doctor or provider to call in a new prescription. Or, your drug store can call the doctor's office for you. Your drug store can call the Pharmacy help desk at **1-877-889-6510** if there any problems, questions, concerns, or need for a claim override.

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 calling Member Services.

If you get a prescription automatically by mail that you do not want, and you were not contacted to find out if you wanted it before it shipped, you may be eligible for a refund.

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 calling Member Services.

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 you are billed and 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.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, please contact us by calling Member Services.

3. Refills on mail-order prescriptions

   For refills, please contact your pharmacy at least 10 business days before your current prescription will run out to make sure your next order is shipped to you in time.

   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. You should ask the drug store the best way to tell them how you want them to get in touch with you.

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 31-day supply has the same copay as a one-month supply. The **Provider and Pharmacy Directory** tells

you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

You can use the plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to the section above 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, and are included in our Drug List. Any restrictions will still apply.
- 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 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 traveling within the United States or its territories and become sick or run out of or lose your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules.
- If you are not able to get 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 a network retail or network 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.
- During a declared disaster, if you get a prescription filled at an out-of-network pharmacy, please call us to help you obtain reimbursement for any out of pocket expense you might have incurred, excluding any applicable copay.

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 believe that you should be paid back for a Texas Medicaid-covered prescription that you already paid for, please call Member Services for help.

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

To learn more about this, refer to Chapter 7.

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 prescription and over-the-counter drugs covered under your Texas Medicaid benefits. 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.

The Drug List includes both brand-name and generic drugs. 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.

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

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

Section B2 How to find a drug on 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 we sent you in the mail.
- Visit the plan's website at **UHCCommunityPlan.com**. The Drug List on the website is always the most current one.
- Call Member Services 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 Connected® 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.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and Texas Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by UnitedHealthcare Connected® 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 (FDA) 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 Texas 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®
- Drugs used for treatment of anorexia, weight loss, or weight gain unless otherwise covered under the Texas Medicaid Vendor Drug Program

- 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 cost sharing tiers

Every drug on the plan's Drug List is in one of 3 cost sharing tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs). In general, the higher the tier, the higher your cost for the drug.

- Tier 1 drugs have the lowest copay. They are generic drugs. The copay will be from $0 to $4.15, depending on your income level.
- Tier 2 drugs have a higher copay. They are brand name drugs. The copay will be from $0 to $10.35, depending on your income level.
- Tier 3 drugs have a $0 copay. They are OTCs/Non-Part D drugs.

To find out which cost sharing tier your drug is in, look for the drug in the plan's Drug List.

Chapter 6 tells the amount you pay for drugs in each cost sharing 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.

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 ***or*** has written "No substitutions" on your prescription for a brand name drug ***or*** has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. Your copay may be greater for the brand name drug than for the generic drug.

2. **Getting plan approval in advance**

   For some drugs, you or your doctor must get approval from UnitedHealthcare Connected® before you fill your prescription. If you don't get approval, UnitedHealthcare Connected® may not cover the drug.

   You can get a 72-hour supply of a drug covered by Texas Medicaid if it is an emergency.

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 or check our website at **UHCCommunityPlan.com**.

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, 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 were in the plan last year.
     - We will cover a temporary supply of your drug during the first 90 days of the calendar year.
     - This temporary supply will be for up to at least 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 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 31 days.
     - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 31 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.
     - For current members with level of care changes: There may be unplanned transitions such as hospital discharges or level of care changes that happen while you are a member in our plan. If you are prescribed a drug that is not on our Drug List or your ability to get your drugs is limited, you must use the plan's exception process. You may ask for a one-time emergency supply of up at least 31 days to allow you time to discuss this with your doctor or to ask for a Drug List exception.
     - 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 you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for next year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

To learn more about asking for an exception, refer to Chapter 9.

If you need help asking for an exception, you can contact Member Services.

Section E Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but UnitedHealthcare Connected® 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 (PA) for a drug. (PA is permission from UnitedHealthcare Connected® 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 Connected®'s up to date Drug List online at **UHCCommunityPlan.com** or Call Member Services to check the current Drug List at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

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 or will be lower. When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.
  - We may not tell you before we make this change, but we 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. If you are notified that a drug you are taking has been taken off the market, you should talk to your doctor or other prescriber.

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.

We may make changes that do not affect the drugs you take 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, increase what you pay for the drug, or limit its use, then the change will not affect your use of the drug or what you pay for 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.

To learn more about drug coverage and what you pay, refer to Chapter 6.

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.

Check your **Provider and Pharmacy Directory** to find out if your long-term care facility's pharmacy is part of our network. 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 anti-anxiety 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.

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
- 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 you 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 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 that 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.

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

UnitedHealthcare Connected® has a program that can help members safely use their prescription opioid medications or 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 or benzodiazepine 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.

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 Texas 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 Texas Medicaid, **and**
- drugs and items covered by the plan as additional benefits.

Because you are eligible for Texas 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 of the 3 cost sharing tiers each drug is in
  - Whether there are any limits on the drugs

  If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at **UHCCommunityPlan.com**. The Drug List on the website is always the most current.
- **Chapter 5 of this Member Handbook.**
  - Chapter 5 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.
- **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.

? **If you have questions,** please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. The call is free. **For more information,** visit **UHCCommunityPlan.com**.

Table of Contents

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 such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. 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.

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 help

you get paid back for our share of the cost of the drug. Contact your Service Coordinator for information on how to get paid back.

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 our share of the cost of the drug, refer to Chapter 7.

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, payments made by a state pharmaceutical assistance program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, UnitedHealthcare Connected® pays all of the costs of your Medicare Part D drugs for the rest of the year.

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. Be sure to keep these EOBs. They are an important record of your drug expenses.

Section C Drug Payment Stages for Medicare Part D drugs

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

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
During this stage, **the plan pays part of the costs** of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, **the plan pays all of the costs** of your drugs through December 31, 2023. You begin this stage when you have paid a certain amount of out-of-pocket costs.

Section C1 The plan's cost sharing tiers

Cost-sharing tiers are groups of drugs with the same copay. Every drug in the plan's Drug List is in one of 3 cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, you can look in the Drug List.

- Tier 1 drugs have the lowest copay. They are generic drugs. The copay is from $0 to $4.15, depending on your income.
- Tier 2 drugs have a higher copay. They are brand name drugs. The copay is from $0 to $10.35, depending on your income.
- Tier 3 drugs have a $0 copay. They are OTCs/Non-Part D drugs.

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 to find out when we will do that.

To learn more about these pharmacy choices, refer to Chapter 5 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 90-day supply. It costs you the same as a one-month supply.

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

Section C4 What you pay

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

You can contact Member Services 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:

	A network pharmacy A one-month or up to a 30-day supply	**The plan's mail-order service** A one-month or up to a 90-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 for details.
Cost Sharing Tier 1 (Generic Drugs)	$0 copay; or $1.45 copay; or $4.15 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $1.45 copay; or $4.15 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $1.45 copay; or $4.15 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $1.45 copay; or $4.15 copay (depending on income level/ the level of Extra Help you receive)
Cost Sharing Tier 2 (Brand Drugs)	$0 copay; or $4.30 copay; or $10.35 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $4.30 copay; or $10.35 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $4.30 copay; or $10.35 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $4.30 copay; or $10.35 copay (depending on income level/ the level of Extra Help you receive)
Cost Sharing Tier 3 (OTCs/ Non-Part D Drugs)	$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 Stage 1: The Initial Coverage Stage

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

Cost sharing tiers are groups of drugs with the same copay. Every drug in the plan's Drug List is in one of 3 cost sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost sharing tiers for your drugs, you can look in the Drug List.

- Tier 1 drugs have the lowest copay. They are generic drugs. The copay is from $0 to $4.15, depending on your income.
- Tier 2 drugs have a higher copay. They are brand name drugs. The copay is from $0 to $10.35, depending on your income.
- Tier 3 drugs have a $0 copay. They are OTCs/Non-Part D drugs.

Section D1 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 to find out when we will do that.

To learn more about these pharmacy choices, refer to Chapter 5 in this handbook and the plan's **Provider and Pharmacy Directory**.

Section D2 Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. It costs you the same as a one-month supply.

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

Section D3 What you pay

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

You can contact Member Services 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:

	A network pharmacy A one-month or up to a 30-day supply	**The plan's mail-order service** A one-month or up to a 90-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 for details.
Cost Sharing Tier 1 (Generic Drugs)	$0 copay; or $1.45 copay; or $4.15 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $1.45 copay; or $4.15 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $1.45 copay; or $4.15 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $1.45 copay; or $4.15 copay (depending on income level/ the level of Extra Help you receive)
Cost Sharing Tier 2 (Brand Drugs)	$0 copay; or $4.30 copay; or $10.35 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $4.30 copay; or $10.35 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $4.30 copay; or $10.35 copay (depending on income level/ the level of Extra Help you receive)	$0 copay; or $4.30 copay; or $10.35 copay (depending on income level/ the level of Extra Help you receive)
Cost Sharing Tier 3 (OTC/Non-Part D Drugs)	$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 D4 End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach $7,400. At that point, the Catastrophic Coverage Stage begins. The plan covers all your drug costs from then until the end of the year.

Your **EOBs** reports will help you keep track of how much you have paid for your drugs during the year. We will let you know if you reach the $7,400 limit. Many people do not reach it in a year.

Section E Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $7,400 for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, the plan will pay all of the costs for your Medicare drugs.

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

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

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects).
- If your doctor agrees, you will not have to pay for the full month's supply for certain drugs.

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

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30 day supply) is $1.45. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days' supply of the drug, your payment will be less than $0.05 per day multiplied by 7 days, for a total payment of less than $0.35.
- Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug, if this will help you:

  – better plan when to refill your drugs,

– coordinate refills with other drugs you take, **and**

– take fewer trips to the pharmacy

Section G Vaccinations

Important Message About What You Pay for Vaccines–Our plan covers most Medicare Part D vaccines at no cost to you. There are twoparts 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 G1 What you need to know before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. **Network pharmacies** are pharmacies that have agreed to work with our plan. A **network provider** is a provider who works with the health plan. A network provider should work with UnitedHealthcare Connected® to ensure that you do not have any upfront costs for a Medicare Part D vaccine.

Section G2 What you pay for a Medicare Part D vaccination

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

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in Chapter 4.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's Drug List. You may have to pay a copay for Medicare Part D vaccines.

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

1. You get the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
   - You will pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office and the doctor gives you the shot.

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

3. You get the Medicare Part D vaccine itself at a pharmacy and take it to your doctor's office to get the shot.
   - You will pay a copay for the vaccine.
   - Our plan will pay for the cost of giving you the vaccine.

Chapter 7

Asking us to pay our share of 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**.

Table of Contents

Section A Asking us to pay for your 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.

If you get a bill for the full cost of health care or drugs, send the bill to us. To send us a bill, refer to page 17 in Chapter 2.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid more than your share of the cost; it is your right to be paid back.
- If the services or drugs are **not** covered, we will tell you.

Contact Member Services if you have any questions. If you do not know what you should have paid, or 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 you back or to pay a bill you got:

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

   You should ask the provider to bill the plan.

   - If you pay the full amount when you get the care, ask us to pay you back for our share of the cost. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill and proof of any payment you made.
     - If the provider should be paid, we will pay the provider directly.
     - If you have already paid more than your share of the cost for the service, we will figure out how much you owed and pay you back for our share of the cost.

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

   Network providers must always bill the plan. Show your UnitedHealthcare Connected® 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 the plan's cost sharing amount for services. **Call Member Services if you get any bills**.

   - Because UnitedHealthcare Connected® 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.
   - If you have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will pay you back for your covered services.

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 prescription.

   - We may cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
   - Please refer to Chapter 5 to learn more about out-of-network pharmacies.

4. **When you pay the full cost for a 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 prescription yourself.
   - Send us a copy of your receipt when you ask us to pay you back for our share of the cost.

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

   You may pay the full cost of the 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).
     - 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).
   - 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 our share of the cost of the drug.

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

To learn how to make an appeal, refer to Chapter 9.

Section B Sending a request for payment

Send us your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It is a good idea to make a copy of your bill and receipts for your records.** You can ask your Service 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 (**UHCCommunityPlan.com**), or you can call Member Services and ask for the form.

Mail your request for payment for prescription drugs or behavioral health services together with any bills or receipts to us at this address:

Prescription drug payment requests:

OptumRx
P.O. Box 29045
Hot Springs, AR 71903

You must submit your prescription drug claim to us within 36 months of the date you received the service, item, or drug.

Behavioral Health payment requests:

OptumHealth Behavioral Solutions
P.O. Box 30760
Salt Lake City, UT 84130

For medical payment requests please call Member Services at **1-800-256-6533** (TTY **711**) from 8 a.m.–8 p.m. local time, M–F and we'll be happy to help you.

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 will also decide the amount, if any, you have to pay for the health care or drug.

- We will let you know if we need more information from you.
- If we decide that the health care or drug is covered and you followed all the rules for getting it, we will pay our share of the cost for it. If you have already paid for the service or drug, we will mail you a check for our share of the cost. If you have not paid for the service or drug yet, we will pay the provider directly.

Chapter 3 explains the rules for getting your services covered. Chapter 5 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for our share of the cost of the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9.

Section D Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called making an appeal. You can also make an appeal if you 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.

- If you want to make an appeal about getting paid back for a health care service, refer page 167 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, refer page 181 in Chapter 9.

Chapter 8

Your rights and responsibilities

Introduction

This chapter includes 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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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. We have written materials available in Spanish. We can provide information in other languages if you ask. We can also give you information in braille or large print. You can call Member Services and ask us to make a note in our system that you would like materials in Spanish, large print, braille, or audio now and in the future.

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**.
- Medicaid at **1-800-252-5263** or **211**. TTY users should call **1-800-735-2989** or **711**.
- You can also contact the HHSC Office of the Ombudsman at **1-877-787-8999** or the Texas Long-Term Care Ombudsman at **1-800-252-2412**.
- Office of Civil Rights at **1-800-368-1019** or TTY **1-800-537-7697**.

Su derecho a recibir servicios e información de una manera que satisfaga sus necesidades

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, sus opciones de salud y tratamiento, y sus derechos de una manera que usted pueda comprender. Informarle sobre los beneficios del plan y sus derechos de una manera que usted pueda comprender. Debemos informarle sobre sus derechos cada año que usted esté inscrito en nuestro plan.

- 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 con personas que pueden responder preguntas en diferentes idiomas.
- Nuestro plan también le puede proporcionar materiales en otros idiomas además de inglés y en otros formatos, como letra grande, braille o audio. Tenemos materiales impresos disponibles en español. Podemos proporcionarle información en otros idiomas, si lo pide. También podemos brindarle información en braille o en letra grande. Llame a Servicio al Cliente y pida que se anote en nuestro sistema que desea recibir los materiales del plan en español, letra grande,

braille o audio a partir de ahora.

- Si tiene alguna dificultad para obtener información de nuestro plan debido a problemas de idioma o una discapacidad y desea presentar una queja, llame 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**. También puede comunicarse con la Oficina del Defensor del Afiliado (Ombudsman) de la Comisión de Salud y Servicios Humanos (HHSC) al **1-877-787-8999** o con el Programa del Ombudsman de Atención a Largo Plazo de Texas al **1-800-252-2412**. A 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 a reasonable opportunity to choose a health plan and primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan.
- A PCP is the doctor or health care provider you will use most of the time and who will coordinate your care. You can find more information about choosing a PCP in Chapter 3.
- Members have the right to be treated with respect and dignity and have the right to privacy.
- Members have the right to candid discussions of treatments options for their conditions, regardless of cost or benefit coverage.
- Members have the right to make recommendations regarding the organization's member rights and responsibility policy.
- Members have the responsibility to supply necessary information to the organization, doctors and providers, in order to provide care.
- Members have a responsibility to understand their health problems and participate in agreed-upon treatment goals.
  - Call Member Services or look in the **Provider and Pharmacy Directory** to learn more about network providers and which doctors are accepting new patients.
- You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
  - Be told how to choose and change your health plan and your PCP.
  - Choose any health plan you want that is available in your area and choose your PCP from that plan.
  - Be told the frequency you can change plans.

  - Be told about other plans available in your area.
- We do not require you to get referrals for network providers.
- You have the right to get covered services from network providers within a reasonable amount of time. If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
  - This includes the right to get timely services from specialists.
  - If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3.
- You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
  - Work as part of a team with your provider in deciding what health care is best for you.
  - Say yes or no to the care recommended by your provider.
- You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
  - Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
  - Get medical care in a timely manner.
  - Get in and out of a health care provider's office. This includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
  - Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
  - Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

Chapter 9 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 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 the privacy of 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 are also required to share your medical records with Texas Medicaid.

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.
- 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.

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

- How we may use your HI.
- When we can share your HI with others.
- What rights you have 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 (**UHCommunityPlan.com**).

- 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, (**UHCommunityPlan.com**).

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 1-800-256-6533, or TTY/RTT 711.**
- **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.

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[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 **1-800-256-6533**, or TTY/RTT **711**.

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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, and your covered services

As a member of UnitedHealthcare Connected®, 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 us at **1-800-256-6533** (TTY **711**, 8 a.m.–8 p.m. local time, M–F. This is a free service. We have written materials in Spanish. We can provide information in other languages if you ask. 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 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
  - Qualifications of our network providers and pharmacies
  - How we pay providers in our network
- A list of providers and pharmacies in the plan's network, in the **Provider and Pharmacy Directory**. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at **UHCCommunityPlan.com**.
- **Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) and about rules you must follow, including:**
  - Services and drugs covered by the plan
  - Limits to your coverage and drugs
  - Rules you must follow to get covered services and drugs
- **Why something is not covered and what you can do about it (refer to Chapter 9), including asking us to:**
  - Put in writing why something is not covered
  - Change a decision we made
  - Pay for a bill you got

Section E Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network 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, refer to Chapter 7.

Section F Your right to leave the plan

No one can make you stay in our plan if you do not want to. You can leave the plan at any time during the year.

- 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 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- You will need to contact MAXIMUS for help with how to get your Texas 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 use another doctor before deciding on treatment.
- **Say "no."** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You 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 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:

- 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**.

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. Organizations that give people information about Medicare or Texas Medicaid, like the Health Information Counseling & Advocacy Program of Texas (HICAP), may also have advance directive forms.
- **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 appropriate state-specific agency, for example, your State Department of Health. See Chapter 2, Section E for contact information regarding your state-specific agency.

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

Chapter 9 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 also have the right to a fair hearing from the state at any time.

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.

You have the right to get a timely answer to a complaint.

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.
- The State Health Insurance Assistance Program (SHIP). **In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For details about this organization and how to contact it, refer to Chapter 2.**
- 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**.)

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, call Member Services.

- **Read the 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 if you have other coverage.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your 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.
  - 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.
  - 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. We expect you to cancel appointments in advance when you cannot keep them and to keep your scheduled appointments.
- **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 Connected® members, Texas Medicaid pays for your Part A premium and for your Part B premium.
  - For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copay (a fixed amount). Chapter 6 tells what you must pay for your drugs.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.

  - **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 Connected®. Chapter 1 tells about our service area.
  - We can help you figure out whether you are moving outside our service area. We can let you know if we have a plan in your new area.
  - Also, be sure to let Medicare and Texas Medicaid know your new address when you move. Refer to Chapter 2 for phone numbers for Medicare and Texas 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 for help if you have questions or concerns.
- You must abide by the health plan's policies and procedures. That includes the responsibility to:
  - Be sure you have approval from your primary care provider before going to a specialist.
- You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
  - Help your providers get your medical records.
  - Work as a team with your Service Coordinator in deciding what health care is best for you.
- You are responsible when using Nonemergency Medical Transportation (NEMT) Services.

That includes the responsibility to:

- Provide information requested by the person arranging or verifying your transportation. (You also must contact the person as soon as possible if something changes and you no longer need the NEMT Service.)
- Follow all rules and regulations affecting your NEMT Services.
- Be respectful. (Do not verbally, sexually, or physically abuse or harass anyone while asking for or getting NEMT Services.)
- Return unused advanced funds. (Provide proof that you kept your medical appointment before you get future advanced funds.)
- Keep bus tickets or tokens safe. (Do not lose them. Only use the bus tickets or tokens to go to your medical appointment, and return any that you do not use.)
- Use NEMT Services only to travel to and from your medical appointments.
- Contact the NEMT Services line right away at **1-866-427-6607**, TTY **1-866-288-3133**, 8:00 a.m.–5:00 p.m., Monday–Friday if your tickets are lost or stolen.
- If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at **1-800-368-1019**. You also can view information concerning the HHS Office of Civil Rights online at **hhs.gov/ocr.**

Chapter 9

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

Introduction

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

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan 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 or long-term services and supports

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 Plan of Care. **If you are having a problem with your care, you can call the HHSC Ombudsman's Office at 1-866-566-8989 for help.** This chapter explains the options you have for different problems and complaints, but you can always call the HHSC Ombudsman's Office to help guide you through your problem.

For additional resources to address your concerns and ways to contact them, refer to Chapter 2, section I. for more information on ombudsman programs.

Chapter 9

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

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 services or payment. Medicare and Texas 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 HHSC Ombudsman’s Office

If you need help, you can always call the HHSC Ombudsman’s Office. The HHSC Ombudsman’s Office can answer your questions and help you understand what to do to handle your problem. Refer to Chapter 2 for more information on ombudsman programs.

The HHSC Ombudsman’s Office 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 HHSC Ombudsman’s Office is **1-866-566-8989**. 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 Texas, the SHIP is called the Health Information Counseling & Advocacy Program (HICAP). The HICAP phone number is **1-800-252-3439**, and their website is **tdi.texas.gov/consumer/hicap/**.

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 (**medicare.gov**).

Getting help from Texas Medicaid

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

- Call **1-512-424-6500** or **2-1-1**. TTY users should call **1-512-424-6597**. The call is free.
- Visit the Texas Medicaid website (**https://hhs.texas.gov/about-hhs/find-us**).

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.	**No.** My problem is not about benefits or coverage.
Refer to **Section D: "Coverage decisions and appeals"** on page 162.	Skip ahead to **Section J: "How to make a complaint"** on page 197.

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 Texas 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 Texas Medicaid. If you or your doctor disagree with our decision, you can appeal.

Section D2 Getting help with coverage decisions and appeals

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 **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

- Call the **HHSC Ombudsman's Offic**e for free help. The HHSC Ombudsman's Office helps people enrolled in Medicaid with service or billing problems. The phone number is **1-866-566-8989**.
- 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 Texas, the SHIP is called the Health Information Counseling & Advocacy Program (HICAP). The phone number is **1-800-252-3439**.
- Talk to **your doctor or other provider**. Your doctor or other 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 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 165 gives you information if you have problems about services, items, and drugs (but **not** 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 that your doctor wants to give you, and you believe this care should be covered.
    - **NOTE:** Only use Section E if these are drugs **not** covered by Part D. Drugs in the **List of Covered Drugs**, also known as the Drug List, with an asterisk (*) are not covered by Part D. Refer to Section F on page 176 for 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 the plan to reimburse you for the services or items.
  - 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 a separate section of this chapter because special rules apply to these types of care. Refer to Sections G and H on pages 185 and 191.
    - 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 176** gives you information about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a 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 (PA) or 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 185** 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 191** 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 **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

If you need other help or information, please call the HHSC Ombudsman's Office at **1-866-566-8989**.

Section E Problems about services, items, and drugs (not 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 Part D, including Medicare Part B drugs. Drugs in the Drug List with an asterisk (*) are **not** covered by Part D. Use Section F for 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 165 for information on asking for a coverage decision.

2. 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 167 for information on making an 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 167 for information on making an appeal.

4. You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items.

   What you can do: You can ask us to pay you back. Refer to Section E5 on page 174 for information on asking us 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 167 for information on making an 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 185 and 191 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: **1-800-256-6533** TTY: **711**, 8 a.m.–8 p.m. local time, M–F.
- You can fax us at: **1-877-940-1972**.
- You can write to us at: UnitedHealthcare Community Plan of Texas, 14141 Southwest Freeway, Suite 500, Sugar Land, TX 77478

How long does it take to get a coverage decision?

It usually takes up to 3 business 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 3 business days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

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 1 business day (or within 24 hours 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 **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F or fax us at **1-877-940-1972**. For details on how to contact us, refer to Chapter 2.
- 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 3 business 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, 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 3 business 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 197.

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 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.

If you need help during the appeals process, you can call the HHSC Ombudsman's Office at **1-866-566-8989**. The HHSC Ombudsman's Office 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 provider, or your representative must contact us. You can call us at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. For additional details on how to reach us for appeals, refer to Chapter 2.

- 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 following address:

  UnitedHealthcare Community Plan
  Attn: Complaint and Appeals Department
  PO Box 6103
  MS CA124-0187
  Cypress, CA 90630
- You may also ask for an appeal by calling us at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

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 fewer 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 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 and ask for one, or visit the Medicare website at **cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.

If you have questions, please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. The call is free. **For more information,** visit **UHCCommunityPlan.com**.

If the appeal comes from someone besides you or your doctor or other 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 fewer 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 171 for more information.

Can I get a copy of my case file?

Yes. Ask us for a copy by calling Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

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 the original decision was based on a lack of medical necessity, then the reviewer will be a physician.

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. 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 197.

- 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. If your problem is about coverage of a Texas 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 171.

If our answer is Yes to part or all 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, we will also send your case to the Independent Review Entity for a Level 2 appeal. If your problem is about coverage of a Texas 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 171.

When will if 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 197.
- 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 Texas 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 171.

If our answer is Yes to part or all 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, we will also send your case to the Independent

Review Entity for a Level 2 appeal. If your problem is about coverage of a Texas 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 171.

Will my benefits continue during Level 1 appeals?

If we decide to change or stop coverage for a service that was previously approved, we will send you a notice before taking the action. If you disagree with the action, you can file a Level 1 Appeal and ask that we continue your benefits. You must **make the request on or before the later of the following** in order to continue your benefits:

- Within 10 calendar days of the mailing date of our notice of action; **or**
- The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service while your appeal is processing.

Section E4 Level 2 Appeal for services, items, and drugs (not 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. This letter will tell you if the service or item is usually covered by Medicare and/or Texas Medicaid.

- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a **Texas Medicaid** service or item, you can ask for a Level 2 Appeal (known as a Fair Hearing) with the Texas Health and Human Services Commission (HHSC) Appeals Division. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Texas Medicaid**, you will automatically get a Level 2 Appeal with the IRE. You can also ask for a Level 2 Appeal (known as a Fair Hearing) with the HHSC Appeals Division.

What is a Level 2 Appeal?

A Level 2 Appeal is an external appeal, which is done by an independent organization that is not connected to the plan. Medicare's Level 2 Appeal organization is the Independent Review Entity (IRE). The IRE is an independent organization hired by Medicare. It is not a government agency. Medicare oversees its work. Texas Medicaid's Level 2 Appeal is known as a Fair Hearing. Requests for a Fair Hearing are filed with UnitedHealthcare Connected®, but reviewed by the HHSC Appeals Division.

My problem is about a Texas Medicaid service or item. How can I make a Level 2 Appeal?

A Level 2 Appeal for Texas Medicaid services and items is called a "Fair Hearing."

If you want to request a Fair Hearing, you must contact UnitedHealthcare Connected® in writing. We will send your Fair Hearing request to the HHSC Appeals Division. You or your representative must ask for a Fair Hearing **within 120 days** of the date on the letter telling you we are denying your Level 1 Appeal to our plan. If you have a good reason for being late, the HHSC Appeals Division may extend this deadline for you.

Mail your written request to:

UnitedHealthcare Community Plan
Attn: Fair Hearings Coordinator
14141 Southwest Freeway
Sugar Land, TX 77478

Or you can call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. We can help you with this request. If you need a fast decision because of your health, you should call Member Services to ask for an expedited Fair Hearing.

After your hearing request is received by the HHSC Appeals Division, you will get a packet of information letting you know the date, time, and location of the hearing. Most Fair Hearings are held by telephone. During the hearing, you or your representative can tell the hearing officer why you need the service that we denied.

The HHSC Appeals Division will give you a final decision within 90 days from the date you asked for the hearing. If you qualify for an expedited Fair Hearing, the HHSC Appeals Division must give you an answer within 72 hours. However, if the HHSC Appeals Division needs to gather more information that may help you, it can take up to 14 more calendar days.

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 hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

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 "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.

What if my service or item is covered by both Medicare and Texas Medicaid?

If your problem is about a service or item that could be covered by both Medicare and Texas Medicaid, we will automatically send your Level 2 Appeal to the Independent Review Entity. You can also ask for a Fair Hearing. Requests for a Fair Hearing are filed with UnitedHealthcare Connected®, but reviewed by the HHSC Appeals Division. Follow the instructions on page 171.

Will my benefits continue during Level 2 appeals?

If your problem is about a service covered by Medicare or both Medicare and Texas Medicaid, your benefits for that service will not continue during Level 2 Appeals.

If your problem is about a service covered by **Texas Medicaid only**, your benefits for that service will continue during the Level 2 Appeal if:

- Your appeal is about our decision to reduce or stop a service that was previously authorized; **and**
- You request a Level 2 Appeal (Fair Hearing) within 10 calendar days of our letter telling you that we were denying your Level 1 appeal or before the intended effective date of the action, whichever is later.

How will I find out about the decision?

If your Level 2 Appeal (Fair Hearing) went to the HHSC Appeals Division, it will notify you in writing of the hearing decision.

- If the HHSC Appeals Division says **Yes** to part or all of what you asked for, we must authorize the coverage within 72 hours from the date we receive the hearing decision.
- If the HHSC Appeals Division 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 your Level 2 Appeal went to the Independent Review Entity (IRE), it will send you a letter explaining its decision.

- 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."

What if I appealed to both the Independent Review Entity and the HHSC Appeals Division and they have different decisions?

If either the Independent Review Entity or the HHSC Appeals Division decides **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you requested in your appeal.

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

If your Level 2 Appeal (Fair Hearing) went to the HHSC Appeals Division, you may appeal again by requesting an administrative review. The letter you get from the HHSC Appeals Division will describe this next appeal option.

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 196 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. The only amount you should be asked to pay is the copay for tier 1 or tier 2 drugs.

If you get a bill for covered services and 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 our share of a bill you have gotten for covered services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement or 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 me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, 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 you the payment for the service or item within 60 calendar days after we get your request.
- 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 167. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back 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 you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment you asked for to you or 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 196 for more information on additional levels of appeal.

If we answer "**No**" to your appeal and the service or item is usually covered by Texas Medicaid, you can file a Level 2 Appeal yourself (refer to Section E4 on page 171).

Section F Part D drugs

Section F1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Texas Medicaid may cover. **This section only applies to Part D drug appeals.**

- The Drug List includes some drugs with an asterisk (*). These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with an asterisk (*) symbol follow the process in Section E on page 165**.**

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

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

- You ask us to make an exception such as:
  - Asking us to cover a 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 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?			
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 an appeal.** (This means you are asking us to reconsider.)
Start with **Section F2** on page 177. Also refer to Sections F3 and F4 on pages 178 and 179.	Skip ahead to **Section F4** on page 179.	Skip ahead to **Section F4** on page 179.	Skip ahead to **Section F5** on page 181.

Section F2 What an exception is

An exception is permission to get coverage for a drug that is not normally on our 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 Part D drug that is not on our Drug List.
    - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in tier 2.
    - 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, Section C, page 115).
   - 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 (PA).")
     - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - Quantity limits. For some drugs, we limit the amount of the drug you can have.
   - If we agree to make an exception and waive a restriction for you, you can still ask for an exception to the copay amount we require you to pay for the drug.

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 181 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 Part D drug or reimbursement for a 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 **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. 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.
- Read Section D on page 162 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 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 Part D 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 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**."

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 197.

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 on 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 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 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 us at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.
- 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.

- 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 **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

The legal term for an appeal to the plan about a 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.

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.

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 179.

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

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.

? **If you have questions,** please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. The call is free. **For more information,** visit **UHCCommunityPlan.com**.

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 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 **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.
- 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 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 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 **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. 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**.

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, you can call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. 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**. The call is free.
- You can also refer to the notice online at **cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices**.
- If you need help, please call Member Services or Medicare at the numbers listed above.

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 will do the Level 1 Appeal review to find out if your planned discharge date is medically appropriate for you. In Texas, the Quality Improvement Organization is called KEPRO.

- To make an appeal to change your discharge date call KEPRO at: **1-888-315-0636** (TTY **711**).

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 G4 on page 189.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at **1-888-315-0636 (TTY 711)** 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 **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. You can also call the State Health Insurance Assistance Program (SHIP) at **1-800-252-3439** or the HHSC Ombudsman's Office at **1-866-566-8989**.

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.

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 **1-800-256-6533** (TTY **711**). 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**. Or you can refer to a sample notice online at **cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html**.

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 Texas, the Quality Improvement Organization is called – KEPRO. You can reach KEPRO at **1-888-315-0636** (TTY **711**).

- 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 **1-888-315-0636** (TTY **711**) and ask for another review.

What happens if the answer is Yes?

- We must pay you back 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 to find out 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 back 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.
- 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.

The legal term for **"fast review"** or "fast appeal" is "**expedited appeal**."

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.

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 of this chapter on page 197 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 back 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.

Prior authorization may be needed — please talk to your PCP or Service Coordinator.

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 when 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 for your care.

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.

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 197 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 **1-800-256-6533** (TTY **711**). Or call your State Health Insurance Assistance Program at **1-800-252-3439**.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Texas, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: **1-888-315-0636** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday. 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 **1-888-315-0636** (TTY **711**) and ask for "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 195.

The legal term for the written notice is "**Notice of Medicare Non-Coverage**." To get a sample copy, call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F 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**.

- 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 our share of the costs of this 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.

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.

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 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

In Texas, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: **1-888-315-0636** (TTY **711**). 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.

- 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 back for our share of 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.

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 to find out 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 back 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 stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

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.

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.

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 197 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.
- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs 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 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 need assistance at any stage of the appeals process, you can contact the HHSC Ombudsman's Office. The phone number is **1-866-566-8989**.

Section I2 Next steps for Medicaid services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Medicaid. If you have questions about your additional appeal rights, you can call the HHSC Ombudsman's Office at **1-866-566-8989**.

If you do not agree with a decision given by the Fair Hearings officer, you may request an Administrative Review within 30 days of the date on the decision.

The letter you get from the HHSC Appeals Division will tell you what to do if you wish to continue the appeals process.

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 or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J3 on page 200.

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.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- UnitedHealthcare Connected® 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.

? **If you have questions,** please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. The call is free. **For more information,** visit **UHCCommunityPlan.com**.

- 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**."

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 HHSC Ombudsman's Office at **1-866-566-8989**.

Section J2 Internal complaints

- To make an internal complaint, call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. You can make the complaint at any time.
- 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.
- If you need to file a "fast complaint" or ask us to reconsider a "fast appeal" you can call Member Services as soon as you are notified that your appeal will follow our standard appeal timeframe or no later than the time frame stated above for sending us 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.

? **If you have questions,** please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. The call is free. **For more information,** visit **UHCCommunityPlan.com**.

- We answer most complaints within 30 calendar days.
- 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/TDD users can call **1-877-486-2048**. The call is free.

You can tell Texas Medicaid about your complaint

Once you have gone through the plan's complaint process, you can submit a complaint to the Texas Health and Human Services Commission (HHSC) by calling toll-free **1-866-566-8989**. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247

If you can get on the Internet, you can submit your complaint at: **https://hhs.texas.gov/about/your-rights/office-ombudsman/hhs-ombudsman-managed-care-help**.

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 contact the local Office for Civil Rights office at: **1-888-388-6332**.

You may also have rights under the Americans with Disability Act and under certain state laws. You can contact the HHSC Ombudsman's Office for assistance. The phone number is **1-866-566-8989**.

You can file a complaint with the Quality Improvement Organization

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).
- 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.

In Texas, the Quality Improvement Organization is called KEPRO. The phone number for KEPRO is **1-888-315-0636** (TTY **711**).

Chapter 10

Ending your membership in our Medicare-Medicaid 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 the Medicare and Texas Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

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Section A When can you end your membership in our Medicare-Medicaid Plan

You can end your membership in UnitedHealthcare Connected®'s Medicare-Medicaid Plan at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

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 on pages 204 and 205 in this Chapter.
- Texas Medicaid services on page 206 in this Chapter.

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

- Call MAXIMUS at **1-703-712-4000**, 8 a.m. – 6 p.m. local time, Monday – Friday. TTY users should call **711**.
- Call the State Health Insurance Assistance Program (SHIP) at **1-800-252-3439**.
- 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**.

NOTE: Effective January 1, 2023, If you are in a drug management program, you may not be able to change plans. Refer to Chapter 5 for information about drug management programs.

Section B How to end your membership in our plan

If you decide to end your membership, tell Texas Medicaid or Medicare that you want to leave UnitedHealthcare Connected®:

- Call MAXIMUS at **1-703-712-4000**, 8 a.m.–6 p.m. local time, Monday–Friday. TTY/TDD users should call **711**; OR
- Send MAXIMUS an Enrollment Change Form. You can get the form by calling MAXIMUS at **1-703-712-4000** (TTY **711**) if you need them to mail you one; OR
- 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 chart on pages 204 and 205.

Section C How to join a different Medicare-Medicaid Plan

If you want to keep getting your Medicare and Texas Medicaid benefits together from a single plan, you can join a different Medicare-Medicaid Plan.

To enroll in a different Medicare-Medicaid Plan:

- Call MAXIMUS at **1-703-712-4000**, 8 a.m.–6 p.m. local time, Monday–Friday. TTY/TTD users should call **711**. Tell them you want to leave UnitedHealthcare Connected® and join a different Medicare-Medicaid Plan. If you are not sure what plan you want to join, they can tell you about other plans in your area; OR
- Send MAXIMUS an Enrollment Change Form. You can get the form by calling MAXIMUS at **1-703-712-4000** (TTY **711**) if you need them to mail you one.

Your coverage with UnitedHealthcare Connected® will end on the last day of the month that we get your request.

Section D How to get Medicare and Medicaid services separately

If you do not want to enroll in a different Medicare-Medicaid Plan after you leave UnitedHealthcare Connected®, you will return to getting your Medicare and Texas Medicaid services separately.

Section D1 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: A Medicare health plan, such as a Medicare Advantage plan or a Program of All-inclusive Care for the Elderly (PACE)	**Here is what to do:** 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 **1-800-252-3439**. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). You will automatically be disenrolled from UnitedHealthcare Connected® when your new plan's coverage begins.

? **If you have questions,** please call UnitedHealthcare Connected® at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F. The call is free. **For more information,** visit **UHCCommunityPlan.com**.

2. You can change to: Original Medicare with a separate Medicare prescription drug plan	**Here is what to do:** 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 **1-800-252-3439**. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). You will automatically be disenrolled from UnitedHealthcare Connected® when your Original Medicare coverage begins.
3. You can change to: Original Medicare without a separate Medicare prescription drug plan **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 Health Information Counseling & Advocacy Program of Texas (HICAP) at **1-800-252-3439**.	**Here is what to do:** 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 **1-800-252-3439**. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). You will automatically be disenrolled from UnitedHealthcare Connected® when your Original Medicare coverage begins.

Section D2 How to get your Medicaid services

Your Texas Medicaid services include most long-term services and supports and behavioral health care. For more information about your Texas Medicaid services please call MAXIMUS at **1-703-712-4000**, 8 a.m.–6 p.m. local time, Monday–Friday. TTY users should call **711**.

If you leave the Medicare-Medicaid Plan, you will remain in our plan to get your Texas Medicaid services.

- You can choose to switch to another Medicaid-only health plan by contacting MAXIMUS.
- You will get a new Member ID Card, a new **Member Handbook**, and a new **Provider and Pharmacy Directory**.

Section E Keep getting your medical services and drugs through our plan until your membership ends

If you leave UnitedHealthcare Connected®, it may take time before your membership ends and your new Medicare and Texas Medicaid coverage begins. During this time, you will keep getting your health care and drugs through our plan.

- **Use our network providers to receive medical care.**
- **You should use our network pharmacies to get your prescriptions filled.** Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

Section F Other situations when your membership ends

These are the cases when UnitedHealthcare Connected® must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Texas Medicaid. Our plan is for people who qualify for both Medicare and Texas Medicaid.
- 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 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 Texas 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 provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Section G 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 Texas Medicaid. Please call your Service Coordinator or Member Advocate for help or you can find Texas Medicaid contact information in Chapter 2.

Section H 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 for information about how to make a complaint.

Section I How to get more information about ending your plan membership

If you have questions or would like more information on when we can end your membership, you can call Member Services at **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

Chapter 11

Legal notices

Introduction

This chapter includes legal notices that apply to your membership in UnitedHealthcare Connected®. 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 Medicaid programs. Other federal and state laws may apply too.

Section B Notice about non-discrimination

Every company or agency that works with Medicare and Texas 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, or sex, or sexual orientation.

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.
- You may also call the Texas Health and Human Services Civil Rights Office at **1-888-388-6332**.

If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section C Notice about Medicare as a second payer

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.

Chapter 12

Definitions of important words

Introduction

This chapter includes key terms used throughout the **Member Handbook** with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living: 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.

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, Section D, page 162 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.

Catastrophic coverage stage: The stage in the Part D drug benefit where the plan pays all of the costs of your drugs until the end of the year. You begin this stage when you have reached the $7,400 limit for your prescription drugs.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2, Section G, page 22 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 Health Risk Assessment: An assessment used to confirm your appropriate risk level and to develop your Plan of Care. Comprehensive Health Risk Assessments will include, but not be limited to, physical and behavioral health, social needs, functional status, wellness and prevention domains, caregiver status and capabilities, as well as your preferences, strengths, and goals.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

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

Cost sharing: Amounts you have to pay when you get services or drugs. Cost sharing includes copays and coinsurance.

Cost sharing tier: A group of drugs with the same copay. Every drug on the **List of Covered Drugs** (also known as the Drug List) is in one of 3 cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

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, Section D, page 162 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.

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

Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.45. This means that the amount you pay for your drug is a little less than $0.05 per day. If you get a 7 days' supply of the drug, your payment will be a little less than $0.05 per day multiplied by 7 days, for a total payment of less than $0.35.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable medical equipment (DME): Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

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.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

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."

Fair hearing: A chance for you to tell your problem in court and show that a decision we made is wrong.

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 made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Service Coordinators to help you manage all 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 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.

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.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- UnitedHeatlhcare Connected must give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your UnitedHealthcare Connected® Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand. Because UnitedHealthcare Connected® pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

Initial coverage stage: The stage before your total Part D drug expenses reach $7,400. This includes amounts you have paid, what our plan has paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays part of the costs of your drugs, and you pay your share.

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, Section H, page 23 for information about how to contact Texas Medicaid.

Medically accepted indication: This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed Plan of Care (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 Assignment: In Original Medicare, a doctor or supplier "accepts assignment" when they agree to accept the Medicare-approved amount as full payment for covered services.

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Texas Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dual eligible beneficiary."

Medicare-Medicaid Plan (MMP): A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has Service Coordinators to help you manage all your providers and services. They all work together to provide the care you need.

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. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Texas Medicaid. UnitedHealthcare Connected® 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 Part D drugs. Texas Medicaid may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Texas 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, Section A, page 15 for information about how to contact Member Services.

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 provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with 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 provid**ers are also called "plan providers."**

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: 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 services are free. You can find more information about the ombudsman in Chapters 2 and 9 of this handbook.

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, Section D, page 162 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, Section D, page 31 explains out-of-network providers or facilities.

Out-of-pocket costs: The cost sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. Refer to the definition for "cost sharing" above.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a healthcare professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to UnitedHealthcare Connected®'s Notice of Privacy Practices for more information about how UnitedHealthcare Connected® protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Plan of Care: A person-centered Plan of Care that addresses health care services you will get and how you will get them. The plan is developed by the Service Coordinator with you, your family, as appropriate, and your providers. The Plan of Care will contain your health history; a summary of current, short-term, and long-term health and social needs, concerns, and goals; and a list of required services, their frequency, and a description of who will provide such services.

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 see any other health care provider.
- Refer to Chapter 3, Section D, page 31 for information about getting care from primary care providers.

Prior authorization (PA): An approval from UnitedHealthcare Connected® you must get before you can get a specific service or drug or use an out-of-network provider. UnitedHealthcare Connected® 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 PA from our plan.

- Covered services that need our plan's PA are marked in the Benefits Chart in Chapter 4 Section D, page 51.

Some drugs are covered only if you get PA from us.

- Covered d**rug**s that need our plan's PA are marked in the **List of Covered Drugs**.

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.

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 patients. Refer to Chapter 2, Section F, page 21 for information about how to contact the QIO for your state.

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 Connected® may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in Chapter 3 and about services that require referrals in Chapter 4.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to Chapter 4, Section D, page 51 to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get UnitedHealthcare Connected®.

Service coordination team: A service coordination team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your service coordination team will also help you make a Plan of Care.

Service 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.

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 Medicaid agency: The Texas Health and Human Services Commission (HHSC) is the single state agency responsible for operating, and in some cases, supervising, the state's Medicaid program.

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

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.

UnitedHealthcare Connected® (Medicare-Medicaid Plan) Member Services:

Call **1-800-256-6533**
Calls to this number are free.
8 a.m.–8 p.m. local time, M–F.
After hours, please call our NurseLine at **1-844-222-7323**. Call **911** or go to the nearest hospital or emergency facility if you think you need emergency care.
We have free interpreter services for people who do not speak English.

TTY **711**
Calls to this number are free.
8 a.m.–8 p.m. local time, Monday–Friday.
After hours, please call our NurseLine at **1-844-222-7323**.

Write: **UnitedHealthcare Community Plan**
P.O. Box 30770
Salt Lake City, TX 77478

UHCCommunityPlan.com
myuhc.com/CommunityPlan

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