Evidence of Coverage 2024

UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS)

Toll-free **1-800-711-0646,** TTY **711**
8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept

myUHCMedicare.com

United Healthcare®

Y0066_EOC_H0755_032_000_2024_C

January 1 – December 31, 2024

Evidence of Coverage

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

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2024.

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

For questions about this document, please contact Customer Service at 1-800-711-0646. (TTY users should call 711). Hours are 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

This plan, UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS), is insured through UnitedHealthcare Insurance Company or one of its affiliates. (When this **Evidence of Coverage** says "we," "us," or "our," it means UnitedHealthcare. When it says "plan" or "our plan," it means UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS).)

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

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at 1-800-711-0646 for additional information (TTY users should call 711). Hours are 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al 1-800-711-0646, para obtener información adicional (los usuarios de TTY deben llamar al 711). El horario es 8 a.m. a 8 p.m.: los 7 días de la semana, de octubre a marzo; de lunes a viernes, de abril a septiembre.

Benefits, premium and/or copayments/coinsurance may change on January 1, 2025.

The provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost-sharing;
- Your medical benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

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

2024 Evidence of Coverage
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Chapter 1

Getting started as a member

Section 1 Introduction

Section 1.1 You are enrolled in UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS), which is a Medicare HMO Point-of-Service Plan

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS). We are required to cover all Part A and Part B services. However, cost-sharing and provider access in this plan differ from Original Medicare.

Our plan is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. "Point-of-Service" means you can use providers outside the plan's network for an additional cost. (See Chapter 3, Section 2.3 for information about using the Point-of-Service option.) UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) does not include Part D prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: irs.gov/Affordable-Care-Act/individuals-and-families for more information.

Section 1.2 What is the Evidence of Coverage document about?

This **Evidence of Coverage** document tells you how to get your medical care. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words "coverage" and "covered services" refer to the medical care and services available to you as a member of the plan.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this **Evidence of Coverage** document.

If you are confused, concerned or just have a question, please contact Customer Service.

Section 1.3 Legal information about the Evidence of Coverage

This **Evidence of Coverage** is part of our contract with you about how the plan covers your care. Other parts of this contract include your enrollment form, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in the plan between January 1, 2024 and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of the plan after December 31, 2024. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

Section 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B
- **— and —** you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- **— and —** you are a United States citizen or are lawfully present in the United States

Section 2.2 Here is the plan service area for UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS)

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

Our service area includes these counties in Connecticut: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, Windham.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Service to see if we have a plan in your new area.

When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

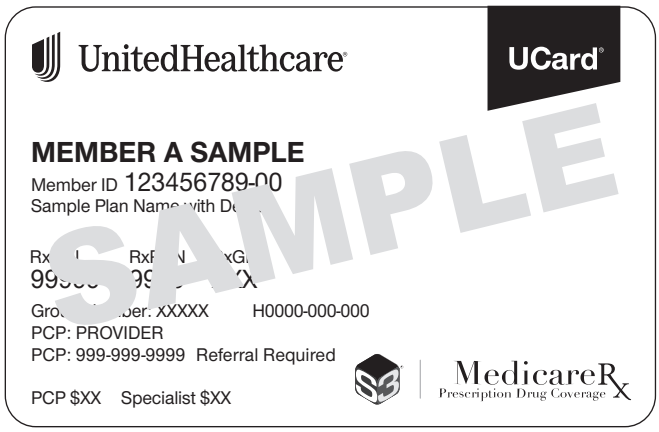
Section 2.3 U.S. Citizen or Lawful Presence

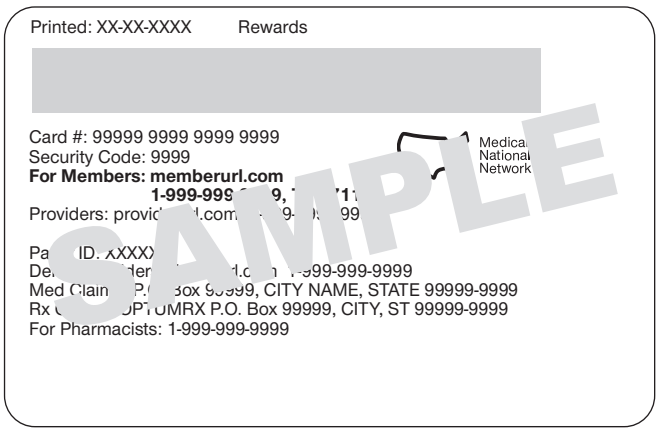
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) if you are not eligible to remain a member on this basis. UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) must disenroll you if you do not meet this requirement.

Section 3 Important membership materials you will receive

Section 3.1 Your UnitedHealthcare member ID card

While you are a member of our plan, you must use your UnitedHealthcare member ID card whenever you get services covered by this plan. You should also show the provider your Medicaid card, if applicable. Here's a sample UnitedHealthcare member ID card to show you what yours will look like:





Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your UnitedHealthcare member ID card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your UnitedHealthcare member ID card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Section 3.2 Provider Directory

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

You must use network providers to get your medical care and services, except for covered routine dental services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers.

Members of this plan may use their Point of Service (POS) benefits to see non-network providers for covered routine dental services only. Please refer to Chapter 3 (Using the plan's coverage for your medical services**)** for more specific information about POS.

The most recent list of providers and suppliers is available on our website at myUHCMedicare.com.

If you don't have your copy of the **Provider Directory**, you can request a copy (electronically or in hardcopy form) from Customer Service. Requests for hard copy Provider Directories will be mailed to you within three business days.

Section 4 Your monthly costs for the plan

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of Medicare & You 2024 handbook, the section called "2024 Medicare Costs." If you need a copy you can download it from the Medicare website (medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for our plan.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

As a member of UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) you receive up to a $40.00 reduction of your monthly Medicare Part B premium. The reduction is set up by Medicare and administered through the Social Security Administration (SSA). Rebates apply only to amounts you pay toward the Medicare Part B premium and are not issued on any premium amount paid by Medicaid. Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Reductions may take several months to be issued; however, you will receive a full credit for amounts you have paid.

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.2 for details. The premium amount for the Platinum Dental Rider is $56.00.

Section 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium

There are four ways you can pay your plan premium.

Option 1: Paying by check

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

Option 2: Electronic Funds Transfer

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

Option 3: Paying by credit card

Instead of paying by check, you can pay your monthly plan premium with your credit card. If you wish to sign up to use your credit card to pay your monthly plan premium please call Customer Service.

Option 4: Having your plan premium taken out of your monthly Social Security check

Changing the way you pay your premium. If you decide to change the option by which you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time. Please contact Customer Service to notify us of your premium payment option choice or if you'd like to change your existing option. (You can find our phone number on the cover of this booklet.)

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the first day of the month. If we have not received your payment by the first day of the month, we will send you a delinquency notice. In addition, we have the right to pursue collection of these premium amounts you owe.

If you are having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your plan premium, you will have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without

creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of the premiums you owe. If you request enrollment in one of our plans and have unpaid premiums in a current or prior plan of ours, we have the right to require payment of any premium amounts you owe, before allowing you to enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 7 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your Part D late enrollment penalty, if owed, within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 7, Section 9 of this document tells how to make a complaint or you can call us at 1-800-711-0646 between 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

Section 6 Keeping your plan membership record up to date

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

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you are participating in 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 of this information changes, please let us know by calling Customer Service.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called Coordination of Benefits.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

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

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

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

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

Chapter 2

Important phone numbers and resources

Section 1 UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) Contacts (how to contact us, including how to reach Customer Service)

How to contact our plan's Customer Service

For assistance with claims, billing, or UnitedHealthcare member ID card questions, please call or write to our plan Customer Service. We will be happy to help you.

Method	Customer Service - Contact Information
Call	**1-800-711-0646** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Write	UnitedHealthcare Customer Service Department P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	**myUHCMedicare.com**

How to contact us when you are asking for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care, see Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions for Medical Care – Contact Information
Call	**1-800-711-0646** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	**711**

Method	Coverage Decisions for Medical Care – Contact Information
	Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	**1-888-950-1170**
Write	UnitedHealthcare Customer Service Department (Organization Determinations) P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	**myUHCMedicare.com**

Method	Appeals for Medical Care – Contact Information
Call	**1-800-711-0646** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept For fast/expedited appeals for medical care: **1-877-262-9203** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	For fast/expedited appeals only: **1-866-373-1081**
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6106, MS CA124-0157, Cypress, CA 90630-0016
Website	**myUHCMedicare.com**

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 7 **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).**

Method	Complaints about Medical Care – Contact Information
Call	**1-800-711-0646**

Method	Complaints about Medical Care – Contact Information
	Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept For fast/expedited complaints about medical care: **1-877-262-9203** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	For fast/expedited complaints only: **1-866-373-1081**
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6106, MS CA124-0157, Cypress, CA 90630-0016
Medicare Website	You can submit a complaint about UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) directly to Medicare. To submit an online complaint to Medicare, go to **medicare.gov/MedicareComplaintForm/home.aspx.**

Where to send a request asking us to pay for our share of the cost for medical care you have received.

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 5 **(Asking us to pay our share of a bill you have received for covered medical services)**.

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))** for more information.

Method	Payment Requests – Contact Information
Call	**1-800-711-0646** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	**711** Calls to this number are free.

Method	Payment Requests – Contact Information
	Hours of Operation: 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Write	Medical claims payment requests: UnitedHealthcare P.O. Box 31362, Salt Lake City, UT 84131-0362
Website	**myUHCMedicare.com**

Section 2 Medicare (how to get help and information directly from the federal Medicare program)

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 (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations, including us.

Method	Medicare – Contact Information
Call	**1-800-MEDICARE,** or **1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Website	**medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information.

Method	Medicare – Contact Information
	• **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an **estimate** of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS): • **Tell Medicare about your complaint:** You can submit a complaint about UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) directly to Medicare. To submit a complaint to Medicare, go to 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 don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can 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 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In your state, the SHIP is called Connecticut CHOICES Senior Health Insurance Program.

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

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

Method to access SHIP and other resources
• Visit https://www.shiphelp.org (Click on SHIP LOCATOR in middle of page) • Select your STATE from the list. This will take you to a page with phone numbers and resources specific to your state.

Method	State Health Insurance Assistance Program (SHIP) – Contact Information Connecticut Connecticut CHOICES Senior Health Insurance Program
Call	1-800-994-9422
TTY	711
Write	55 Farmington AVE, FL 12, Hartford, CT 06105-3730
Website	https://portal.ct.gov/AgingandDisability/Content-Pages/Programs/CHOICES-Connecticuts-program-for-Health-insurance-assistance-Outreach-Information-and-referral-Couns

Section 4 Quality Improvement Organization

There is a designated Quality Improvement Organization serving Medicare beneficiaries in each state. For Connecticut, the Quality Improvement Organization is called KEPRO.

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

You should contact your state's Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Quality Improvement Organization (QIO) – Contact Information Connecticut KEPRO
Call	1-888-319-8452 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Method	Quality Improvement Organization (QIO) – Contact Information Connecticut KEPRO
Write	5201 W Kennedy BLVD, STE 900, Tampa, FL 33609
Website	**www.keproqio.com**

Section 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

Section 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact your state Medicaid agency.

Method	State Medicaid Program – Contact Information Connecticut Connecticut State Medicaid (Medicaid)
Call	**1-877-284-8759** **8:30 a.m. - 6:00 p.m. local time, Monday - Friday**
TTY	**1-866-492-5276** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	55 Farmington AVE, Hartford, CT 06105-3730
Website	**portal.ct.gov/husky**

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance. **Note:** To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP office listed below.

Method	AIDS Drug Assistance Program (ADAP) – Contact Information Connecticut ADAP
Call	**1-800-424-3310** **8 a.m.-4 p.m. local time, Monday-Friday**
Website	**https://ctdph.magellanrx.com**

Section 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
Call	**1-877-772-5772** Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
Website	**rrb.gov/**

Section 8 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the cover of this document .) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

Chapter 3

Using the plan for your medical services

Section 1 Things to know about getting your medical care as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, Part B prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 **(Medical Benefits Chart, what is covered and what you pay).**

Section 1.1 What are "network providers" and "covered services"?

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

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

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

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a

provider who is not part of our plan's network) will not be covered. This means you will have to pay the provider in full for the services furnished. **Here are three exceptions:**

- The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
- If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost-sharing you normally pay in-network. In this situation, you will pay the same as you would pay if you got the care from a network provider. You must get approval from us before you start receiving care from an out-of-network provider. Please contact Customer Service, or have your PCP or the out-of-network provider call us to get approval (phone numbers are printed on the cover of this booklet).
- The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost-sharing you pay the plan for dialysis can never exceed the cost-sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost-sharing cannot exceed the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost-sharing for the dialysis may be higher.

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

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

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

What is a "PCP" and what does the PCP do for you?

What is a PCP?

A primary care provider (PCP) is a network physician who is selected by you to provide and coordinate your covered services.

What types of providers may act as a PCP?

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

What is the role of my PCP?

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

PCP after any specialist visits. It is important for you to develop and maintain a relationship with your PCP.

How do you choose your PCP?

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

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

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

Changing your PCP

You may change your PCP for any reason, at any time. Also, it’s possible that your PCP might leave our plan’s network of providers and you would have to find a new PCP.

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

Section 2.2 How to get care from specialists and other network providers

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

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

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

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

Please refer to the **Provider Directory** for a listing of plan specialists available through your network, or you may consult the **Provider Directory** online at the website listed in Chapter 2 of this booklet.

What if a specialist or another network provider leaves our plan?

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

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

Some services require prior authorization from the plan in order to be covered. Obtaining prior authorization is the responsibility of the PCP or treating provider. Services and items requiring prior authorization are listed in Medical Benefits Chart in Chapter 4, Section 2.1.

Section 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers for routine dental services only. For more information see the **"Covered Routine Dental Benefits" in Chapter 4**. Otherwise, care that you receive from out-of-network providers will not be covered unless the care meets one of the three exceptions described in Section 1.2 of this chapter. For information about getting out-of-network care when you have a medical emergency or urgent need for care, please see Section 3 in this chapter.

Section 3 How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

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

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

What if it wasn't a medical emergency?

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

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

- You go to a network provider to get the additional care.
- **–or–** The additional care you get is considered "urgently needed services" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

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

What are "urgently needed services"?

An urgently needed service is a non-emergency situation requiring immediate medical care but, given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out-of-network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

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

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

Section 3.3 Getting 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 your plan.

Please visit the following website: uhc.com/disaster-relief-info or contact Customer Service for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing.

Section 4 What if you are billed directly for the full cost of your services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 **(Asking us to pay our share of a bill you have received for covered medical services)** for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Our plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. For example, if your plan covers one routine physical exam per year and you receive that routine physical but choose to have a second routine physical within the same year, you pay the full cost of the second routine physical. Any amounts that you pay after you have reached the benefit limitation do not count toward your annual out-of-pocket maximum. (See Chapter 4 for more information on your plan's out-of-pocket maximum.)

Section 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study **and** you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for in-network cost-sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost-sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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 PCP. The providers that deliver your care as part of the clinical research study do **not** need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has not approved you will be responsible for paying all costs for your participation in the study.

Section 5.2 When you participate in a clinical research study, who pays for what?

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

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost-sharing in Original Medicare and your in-network cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost-sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

- Generally, Medicare will **not** pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were **not** in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at: 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 6 Rules for getting care in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

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

Section 6.2 Receiving 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 conscientiously opposed to getting medical treatment that is "non-excepted."

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive 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 conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - **and –** you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

You are covered for unlimited days in the hospital, as long as your stay meets Medicare coverage guidelines. The coverage limits are described under **inpatient hospital care** in the medical benefits chart in Chapter 4.

Section 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will

transfer ownership of the durable medical equipment item. Call Customer Service for more information.

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

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

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

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

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

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

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

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

Chapter 4

Medical Benefits Chart (what is covered and what you pay)

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

This chapter provides a medical benefits chart that lists your covered services and shows how much you will pay for each covered service as a member of UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The medical benefits chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The medical benefits chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance for Medicare-covered services. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket amount for medical services. For calendar year 2024 this amount is $6,000.

The amounts you pay for your copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premium do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the medical benefits chart. If you reach the maximum out-of-pocket amount of $6,000, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Connecticut State Medicaid (Medicaid) or another third party).

Section 1.3 Our plan does not allow network providers to "balance bill" you

As a member of UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS), an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called "balance billing."

This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00) then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has "balance billed" you, call Customer Service.

Section 2 Use the medical benefits chart to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The medical benefits chart on the following pages lists the services UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) covers and what you pay out-of-pocket for each service. The services listed in the medical benefits chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) **must** be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a Primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the medical benefits chart are covered **only** if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS).
  - Covered services that may need approval in advance are marked by a double dagger (††) in the medical benefits chart.

  – Network providers agree by contract to obtain prior authorization from the plan and agree not to balance bill you.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay **more** in our plan than you would in Original Medicare. For others, you pay **less**. (If you want to know more about the coverage and costs of Original Medicare, look in your **Medicare & You 2024** handbook. View it online at medicare.gov or ask for a copy 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.)
- For all Preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

You will see this apple next to the Preventive services in the benefits chart.

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

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

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

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

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Providers may ask you for more than one cost share payment if you get more than one service at an appointment. For example: •Your doctor will ask for a copayment for the office or urgent care center visit and additional copayments for each x-ray that is performed while you are there. •Your hospital may ask for separate cost-sharing for certain outpatient hospital medical services for example but not limited to; radiological tests or Medicare Part B drugs administered while you are there. •The specific cost-sharing that will apply depends on which services you receive. The Medical benefits chart below lists the cost-sharing that applies for each specific service.	
Abdominal aortic aneurysm screening A one-time (once per lifetime) screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days performed by, or under the supervision of a physician (or other medical provider as described below) are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: •Lasting 12 weeks or longer; •nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); •not associated with surgery; and •not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Generally, Medicare-covered acupuncture services are not covered when provided by an acupuncturist or chiropractor.** Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: •a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the	You will pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/practitioner services, including doctor's office visits") depending on if you receive services from a primary care physician or specialist.[††]

Services that are covered for you	What you must pay when you get these services
Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. • Benefit is not covered when solely provided by an independent acupuncturist. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS as required by Medicare. Acupuncture services performed by providers that do not meet CMS acupuncture provider requirements are not covered even in locations where there are no providers available that meet CMS requirements.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$290 copayment for each one-way Medicare-covered ground trip. $290 copayment for each one-way Medicare-covered air trip. You pay these amounts until you reach the out-of-pocket maximum. All Medicare-covered trips (in or out-of-network) will apply to the in-network out-of-pocket maximum. *Your provider may need to obtain prior authorization for non-emergency transportation.*

Services that are covered for you	What you must pay when you get these services
Annual routine physical exam Includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. Annual Routine Physical Exam visits do not need to be scheduled 12 months apart but are limited to one visit each calendar year.	$0 copayment for a routine physical exam each year.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
Breast cancer screening (mammograms) Covered services include: •One baseline mammogram between the ages of 35 and 39 •One screening mammogram every 12 months for women age 40 and older •Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copayment for each Medicare-covered cardiac rehabilitative visit.[††]
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) covered once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening Covered services include: •For all women: Pap tests and pelvic exams are covered once every 24 months •If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months •For asymptomatic women between the ages of 30 and 65: HPV testing once every 5 years, in conjunction with the Pap test	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: •Manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position). Manual manipulation is a treatment that uses hands-on pressure to gently move your joints and tissues. Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation, including: •Maintenance therapy. Chiropractic treatment is considered maintenance therapy when continuous ongoing care is no longer expected to provide clinical improvements and the treatment becomes supportive instead of corrective. •Extra charges when your chiropractor uses a manual, hand-held device to add controlled pressure during treatment.	$15 copayment for each Medicare-covered visit.[††] You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
•X-rays, massage therapy, and acupuncture (unless the acupuncture is for the treatment of chronic low back pain).	
Colorectal cancer screening The following screening tests are covered: •Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. •Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. •Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. •Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. •Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. •Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. •Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes an outpatient diagnostic colonoscopy. There is no coinsurance, copayment, or deductible for each Medicare-covered barium enema.

Services that are covered for you	What you must pay when you get these services
screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	
Outpatient diagnostic colonoscopy	There is no coinsurance, copayment, or deductible for each Medicare-covered diagnostic colonoscopy.††
Routine dental benefits You can get more information about this benefit by viewing the Vendor Information Sheet at myUHCMedicare.com or by calling Customer Service to have a paper copy sent to you.	You are covered for routine dental benefits. See the routine dental benefit description at the end of this chart for details.*††
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every plan year.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include:	
• Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	$0 copayment for each Medicare-covered diabetes monitoring supply.[††]
UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) covers any blood glucose monitors and test strips specified within this list. 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 UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) and are using a brand of blood glucose monitors and test strips that is 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. If you or your doctor believe it is medically necessary for you to maintain use of an alternate brand, you may request a coverage exception to have UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) 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	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. $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.[††]

Services that are covered for you	What you must pay when you get these services
Chapter 7, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).)	Insulin and syringes are not covered.
• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	20% coinsurance for each pair of Medicare-covered therapeutic shoes.[††] You pay these amounts until you reach the out-of-pocket maximum.
• Diabetes self-management training is covered under certain conditions. Limited to 20 visits of 30 minutes per year for a maximum of 10 hours the initial year. Follow-up training subsequent years after, limited to 4 visits of 30 minutes for a maximum of 2 hours per year.	$0 copayment for Medicare-covered benefits.
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 10 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at myUHCMedicare.com.	20% coinsurance for Medicare-covered benefits.[††] Your cost-sharing for Medicare oxygen equipment coverage is 20% coinsurance, every time you get covered equipment or supplies.[††] Your cost-sharing will not change after being enrolled for 36 months. If prior to enrolling in our plan you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in our plan is 20% coinsurance.[††]

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
	You pay these amounts until you reach the out-of-pocket maximum.
Emergency care Emergency care refers to services that are: •Furnished by a provider qualified to furnish emergency services, and •Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	$120 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you are admitted to a hospital, you will pay cost-sharing as described in the "Inpatient hospital care" section in this benefit chart. You pay these amounts until you reach the out-of-pocket maximum.
Worldwide coverage for emergency department services outside of the United States. •This includes emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. •Transportation back to the United States from another country is not covered. •Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures are not covered. •Services provided by a dentist are not covered.	$0 copayment for worldwide coverage for emergency services outside of the United States. Please see Chapter 5 Section 1.1 for expense reimbursement for worldwide services. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a

Services that are covered for you	What you must pay when you get these services
	network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.
Fitness program Renew Active® by UnitedHealthcare® Renew Active by UnitedHealthcare is the gold standard in Medicare fitness programs for body and mind. It's available to you at no additional cost and includes: •A free gym membership, access to our nationwide network of gyms and fitness locations, a personalized fitness plan plus thousands of on-demand workout videos and live streaming fitness classes. •An online program from AARP® Staying Sharp® offering content about brain health with exclusive content for Renew Active members. •Social activities at local health and wellness classes, clubs and events. •An online Fitbit® Community for Renew Active. No Fitbit device is needed. You can get more information by viewing the Vendor Information Sheet at myUHCMedicare.com or by calling Customer Service to have a paper copy sent to you.	Provided by: Renew Active® $0 copayment A home-delivered fitness kit is available if you live 15 miles or more from a Renew Active network gym or fitness location.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment	$0 copayment for each Medicare-covered exam.[††]

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	
Hearing services - routine hearing exam We cover 1 hearing exam every year.	Provided by: Plan network providers in your service area $0 copayment
Hearing services - hearing aids: Through UnitedHealthcare Hearing, you can choose from a broad selection of over-the-counter (OTC) hearing aids, name-brand prescription hearing aids, or UnitedHealthcare Hearing's brand Relate®. Hearing aids can be fit in-person with a network provider or delivered directly to you with virtual follow-up care (select models). This benefit is limited to 2 hearing aids every year. Hearing aid accessories, additional batteries and optional services are available for purchase, but they are not covered by the plan. To access your hearing aid benefit and get connected with a network provider, you must contact UnitedHealthcare Hearing at 1-855-523-9355, TTY 711 or UHCHearing.com/Medicare.	Provided by: UnitedHealthcare Hearing $99 copay for each Tier 1 hearing aid.* $199 copay for each Tier 2 hearing aid.* $429 copay for each Tier 3 hearing aid.* $599 copay for each Tier 4 hearing aid.* $829 copay for each Tier 5 hearing aid.* $1,249 copay for each Tier 6 hearing aid.* You must obtain prior authorization from UnitedHealthcare Hearing. Additional fees may apply for optional follow-up visits. Home-delivered hearings aids are available nationwide through UnitedHealthcare Hearing (select products only). Hearing aids purchased outside of UnitedHealthcare Hearing are not covered.

Services that are covered for you	What you must pay when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: •One screening exam every 12 months For women who are pregnant, we cover: •Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: •Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) •Physical therapy, occupational therapy, and speech therapy •Medical and social services •Medical equipment and supplies	$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met.[††] Other copayments or coinsurance may apply (Please see Durable medical equipment and related supplies for applicable copayments or coinsurance).
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to:	You will pay the cost-sharing that applies to primary care services, specialist physician services, or home health (as described under “Physician/ practitioner services, including doctor’s office visits” or “Home health agency care”) depending on where you received

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
•Professional services, including nursing services, furnished in accordance with the plan of care •Patient training and education not otherwise covered under the durable medical equipment benefit •Remote monitoring •Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	administration or monitoring services.[††] See "Durable medical equipment" earlier in this chart for any applicable cost-sharing for equipment and supplies related to home infusion therapy. [††] See "Medicare Part B prescription drugs" later in this chart for any applicable cost-sharing for drugs related to home infusion therapy.[††]
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: •Drugs for symptom control and pain relief •Short-term respite care •Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost-sharing. **For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization): • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) but are not covered by Medicare Part A or B: UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through	

Services that are covered for you	What you must pay when you get these services
our network providers will lower your share of the costs for the services.	
Immunizations Covered Medicare Part B services include: •Pneumonia vaccine •Flu vaccine, one 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 coverage rules	There is no coinsurance, copayment, or deductible for the pneumonia, flu, Hepatitis B, or COVID-19 vaccines. There is no coinsurance, copayment, or deductible for all other Medicare-covered immunizations.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include, but are not limited to: •Semi-private room (or a private room if medically necessary) •Meals including special diets •Regular nursing services •Costs of special care units (such as intensive care or coronary care units) •Drugs and medications •Lab tests •X-rays and other radiology services •Necessary surgical and medical supplies	$395 copayment each day for days 1 to 7 for Medicare-covered hospital care each time you are admitted. $0 copayment for additional Medicare-covered days.[††] You pay these amounts until you reach the out-of-pocket maximum. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions of

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Services that are covered for you	What you must pay when you get these services
•Use of appliances, such as wheelchairs •Operating and recovery room costs •Physical, occupational, and speech language therapy •Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. The plan has a network of facilities that perform organ transplants. The plan's hospital network for organ transplant services is different than the network shown in the 'Hospitals' section of your provider directory. Some hospitals in the plan's network for other medical services are not in the plan's network for transplant services. For information on network facilities for transplant services, please call UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) Customer Service at 1-800-711-0646 TTY 711. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) provides transplant services at a location outside of the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. While you are receiving care at the distant location, we will also reimburse transportation costs to and from the hospital or doctor's office for evaluations, transplant services and follow-up care. (Transportation in the distant location includes, but is not limited to: vehicle mileage, economy/coach airfare,	important words.) For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

Services that are covered for you	What you must pay when you get these services
taxi fares, or rideshare services.) Costs for lodging or places to stay such as hotels, motels or short-term housing as a result of travel for a covered organ transplant may also be covered. You can be reimbursed for eligible costs up to $125 per day total. Transportation services are not subject to the daily limit amount. •Blood - including storage and administration. Coverage begins with the first pint of blood that you need. •Physician services	
Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "outpatient observation" stay. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.

Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital Covered services include: • Mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. • Inpatient substance abuse services	$395 copayment each day for days 1 to 5 for Medicare-covered hospital care each time you are admitted. $0 copayment for additional Medicare-covered days, up to 90 days per benefit period. Plus an additional 60 lifetime reserve days.[††] You pay these amounts until you reach the out-of-pocket maximum. Medicare hospital benefit periods are used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in the chapter titled Definitions of important words.) However, the cost-sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times within a benefit period.
Inpatient stay: covered services received in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:	When your stay is no longer covered, these services will be covered as described in the following sections:

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Services that are covered for you	What you must pay when you get these services
•Physician services	Please refer below to Physician/ practitioner services, including doctor's office visits.
•Diagnostic tests (like lab tests)	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
•X-ray, radium, and isotope therapy including technician materials and services	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
•Surgical dressings •Splints, casts and other devices used to reduce fractures and dislocations	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
•Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	Please refer below to Prosthetic devices and related supplies.
•Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	Please refer below to Prosthetic devices and related supplies.
•Physical therapy, speech language therapy, and occupational therapy	Please refer below to Outpatient rehabilitation services.

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Services that are covered for you	What you must pay when you get these services
Meal benefit This benefit can be used immediately following an inpatient hospital or skilled nursing facility (SNF) stay. Benefit guidelines: • Receive up to 28 home-delivered meals for up to 14 days • First meal delivery may take up to 72 hours after ordered	Provided by: Roots Food Group® $0 copayment Prior authorization is required. Home-delivered meals are available nationwide through Roots Food Group.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare diabetes prevention program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Services that are covered for you	What you must pay when you get these services
Medicare Part B Prescription Drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by 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 • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens (for allergy shots) • 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) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	$0 copayment for Medicare-covered Part B allergy antigens.[††] 20% coinsurance for each Medicare-covered chemotherapy drug and the administration of that drug. You may pay less for certain rebatable drugs. This list and the cost of each rebatable drug changes every quarter.[††] You pay these amounts until you reach the out-of-pocket maximum. 20% coinsurance for all other Medicare-covered Part B drugs.[††] You may pay less for certain rebatable drugs. This list and the cost of each rebatable drug changes every quarter. For the administration of these drugs, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you received drug administration or infusion services. You will pay a maximum of $35 for each 1-month supply of Part B covered insulin.

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Services that are covered for you	What you must pay when you get these services
• 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://www.medicare.uhc.com/medicare/member/documents/part-b-step-therapy.html 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 7, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).) Please contact Customer Service for more information. We also cover some vaccines under our Part B prescription drug benefit.	You pay these amounts until you reach the out-of-pocket maximum.
Nurse Hotline Nurse Hotline services available, 24 hours a day, 7 days a week. Speak to a registered nurse (RN) about your medical concerns and questions. You can view the Vendor Information Sheet at myUHCMedicare.com, or call Customer Service to have a paper copy sent to you.	Provided by: NurseLine $0 copayment

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Services that are covered for you	What you must pay when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: •U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. •Dispensing and administration of MAT medications (if applicable) •Substance use counseling •Individual and group therapy •Toxicology testing •Intake activities •Periodic assessments	$0 copayment for Medicare-covered opioid treatment program services.[††]
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to:	

Services that are covered for you	What you must pay when you get these services
•X-rays	$25 copayment for each Medicare-covered standard X-ray service.[††] You pay these amounts until you reach the out-of-pocket maximum.
•Radiation (radium and isotope) therapy including technician materials and supplies	$60 copayment for each Medicare-covered radiation therapy service.[††] You pay these amounts until you reach the out-of-pocket maximum.
•Surgical supplies, such as dressings •Splints, casts, and other devices used to reduce fractures and dislocations Note: There is no separate charge for medical supplies routinely used in the course of an office visit and included in the provider's charges for that visit (such as bandages, cotton swabs, and other routine supplies.) However, supplies for which an appropriate separate charge is made by providers (such as, chemical agents used in certain diagnostic procedures) are subject to cost-sharing as shown.	20% coinsurance for each Medicare-covered medical supply.[††] You pay these amounts until you reach the out-of-pocket maximum.
•Laboratory tests	$0 copayment for Medicare-covered lab services.[††]

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Services that are covered for you	What you must pay when you get these services
• Blood - including storage and administration (this means processing and handling of blood). Coverage begins with the first pint of blood that you need. • In addition, for the administration of blood infusion, you will pay the cost-sharing as described under the following sections of this chart, depending on where you received infusion services: – Physician/practitioner services, including doctor's office visits – Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers	$0 copayment for Medicare-covered blood services.[††]
• Other outpatient diagnostic tests - non-radiological diagnostic services	$45 copayment for Medicare-covered non-radiological diagnostic services.[††] Examples include, but are not limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests. You pay these amounts until you reach the out-of-pocket maximum.

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Services that are covered for you	What you must pay when you get these services
•Other outpatient diagnostic tests - radiological diagnostic services, not including x-rays.	$0 copayment for each diagnostic mammogram or vascular screening.[††] $250 copayment for other Medicare-covered radiological diagnostic services, not including X-rays, performed in a physician's office or at a free-standing facility (such as a radiology center or medical clinic).[††] You pay these amounts until you reach the out-of-pocket maximum. The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).

Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7days a week.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: •Services in an emergency department	Please refer to Emergency Care.

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Services that are covered for you	What you must pay when you get these services
•Laboratory and diagnostic tests billed by the hospital	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
•Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	Please refer to Outpatient mental health care.
•X-rays and other radiology services billed by the hospital	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
•Medical supplies such as splints and casts	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
•Certain screenings and preventive services	Please refer to the benefits preceded by the “Apple” icon.
•Certain drugs and biologicals that you can’t give yourself	Please refer to Medicare Part B prescription drugs.
•Services performed at an outpatient clinic	Please refer to Physician/ practitioner services, including doctor's office visits.
•Outpatient surgery or observation	Please refer to Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.

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Services that are covered for you	What you must pay when you get these services
•Outpatient infusion therapy For the drug that is infused, you will pay the cost-sharing as described in "Medicare Part B prescription drugs" in this benefit chart. In addition, for the administration of infusion therapy drugs, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under “Physician/practitioner services, including doctor’s office visits” or “Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers” in this benefit chart) depending on where you received drug administration or infusion services.	Please refer to Medicare Part B prescription drugs and Physician/practitioner services, including doctor’s office visits or Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” This is called an “outpatient observation” stay. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional	$25 copayment for each Medicare-covered **individual** therapy session.[††]

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Services that are covered for you	What you must pay when you get these services
counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$15 copayment for each Medicare-covered **group** therapy session.[††] You pay these amounts until you reach the out-of-pocket maximum.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, physician offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$35 copayment for each Medicare-covered physical therapy and speech-language therapy visit.[††] You pay these amounts until you reach the out-of-pocket maximum. $35 copayment for each Medicare-covered occupational therapy visit.[††] You pay these amounts until you reach the out-of-pocket maximum.
Outpatient substance abuse services Outpatient treatment and counseling for substance abuse.	$25 copayment for each Medicare-covered **individual** therapy session.[††] $15 copayment for each Medicare-covered **group** therapy session.[††] You pay these amounts until you reach the out-of-pocket maximum.
Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers	$0 copayment for a colonoscopy at an ambulatory surgical center.[††]

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Services that are covered for you	What you must pay when you get these services
Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "Outpatient Observation" stay. If you are not sure if you are an outpatient, you should ask your doctor or the hospital staff. If you receive any services or items other than surgery, including but not limited to diagnostic tests, therapeutic services, prosthetics, orthotics, supplies or Part B drugs, there may be additional cost-sharing for those services or items. Please refer to the appropriate section in this chart for the additional service or item you received for the specific cost-sharing required. See "Colorectal cancer screening" earlier in this chart for screening and diagnostic colonoscopy benefit information.	$345 copayment for Medicare-covered surgery or other services provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges.[††] You pay these amounts until you reach the out-of-pocket maximum. $0 copayment for a colonoscopy at an outpatient hospital.[††] $395 copayment for Medicare-covered surgery or other services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges.[††] You pay these amounts until you reach the out-of-pocket maximum. Outpatient surgical services that can be delivered in an available ambulatory surgery center must be delivered in an ambulatory surgery center unless a hospital outpatient department is medically necessary.

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Services that are covered for you	What you must pay when you get these services
	$395 copayment for each day of Medicare-covered observation services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges.[††] You pay these amounts until you reach the out-of-pocket maximum.
Over-the-counter (OTC) credit With this benefit, you'll get a credit loaded to your UnitedHealthcare UCard® each quarter to buy covered OTC items. Credits are added on the first day of each quarter (in January, April, July and October) and expire on the last day of each quarter (March 31, June 30, September 30 and December 31). Covered items include brand name and generic OTC products like vitamins, pain relievers, toothpaste, and first aid products. The credit cannot be used to buy tobacco or alcohol.	Provided by: Solutran Quarterly credit is $50
Home and bath safety devices You can also use your OTC credit on covered home and bath safety devices like bathmats, grab bars and shower chairs. You can use your credit at thousands of participating stores or place an order online. Home shipping is free and there is a $35 minimum to place an order.	Combined with OTC credit amount Home shipped OTC products and home and bath safety devices are available nationwide.

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Services that are covered for you	What you must pay when you get these services
Visit the UCard Hub at myUHCMedicare.com to find participating stores, check your balance or place an order online.	
Partial hospitalization services and Intensive outpatient services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	$55 copayment each day for Medicare-covered benefits.[††] You pay these amounts until you reach the out-of-pocket maximum.
Physician/practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical or surgical services furnished in a physician's office.	$0 copayment for services from a primary care physician or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a primary care physician's office (as allowed by Medicare).

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Services that are covered for you	What you must pay when you get these services
•Medically-necessary medical or surgical services furnished in a certified ambulatory surgical center or hospital outpatient department.	See "Outpatient surgery" earlier in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.
•Consultation, diagnosis, and treatment by a specialist.	$35 copayment for services from a specialist or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a specialist's office (as allowed by Medicare).[††] You pay these amounts until you reach the out-of-pocket maximum.
•Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment.	$0 copayment for each Medicare-covered exam.[††]
•Medicare-covered telehealth services including: – Medical and mental health visits delivered to you outside of medical facilities by providers that have appropriate online technology and live audio/video capabilities to conduct the visit. – Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment. – Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based	$0 copayment for each Medicare-covered visit.[††]

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Services that are covered for you	What you must pay when you get these services
renal dialysis center, renal dialysis facility, or the member's home. – Telehealth services provided by rural health clinics and federally qualified health centers. – Medicare-covered remote monitoring services. – Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: • You're not a new patient and • The check-in isn't related to an office visit in the past 7 days and • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. – Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: • You're not a new patient and • The evaluation isn't related to an office visit in the past 7 days and • The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment. – Consultation your doctor has with other doctors by phone, internet, or electronic health record.	
• Second opinion by another network provider prior to surgery.	You will pay the cost-sharing that applies to specialist services (as described under "Physician/practitioner services, including doctor's office visits" above).††
• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures	20% coinsurance for each Medicare-covered visit.††

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, oral exams before a kidney transplant or services that would be covered when provided by a physician). Dental services provided by a dentist in connection with care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not Medicare-covered benefits and not covered under this benefit.	You pay these amounts until you reach the out-of-pocket maximum.
• Monitoring services in a physician's office or outpatient hospital setting if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as 'Coumadin Clinic' services).	You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you receive services.††
• Medically-necessary medical or surgical services that are covered benefits and are furnished by a physician/ non-physician health care professional in your home or a nursing home in which you reside.	$0 copayment for primary care provider services or, in certain circumstances, nurse practitioner, physician's assistant or other non-physician health care professional services.†† $35 copayment for specialist physician services.†† You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
Podiatry services Covered services include: •Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). •Routine foot care for members with certain medical conditions affecting the lower limbs.	$35 copayment for each Medicare-covered visit in an office or home setting.[††] For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers. You pay these amounts until you reach the out-of-pocket maximum.
Additional routine foot care We cover 6 routine foot care visits every year. This benefit is in addition to the Medicare-covered podiatry services benefit listed above. Covered services include treatment of the foot which is generally considered preventive, i.e., cutting or removal of corns, warts, calluses or nails.	$35 copayment for each routine visit.*
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: •Digital rectal exam •Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for each Medicare-covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test. Diagnostic PSA exams are subject to cost-sharing as described under Outpatient diagnostic tests and therapeutic

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Services that are covered for you	What you must pay when you get these services
	services and supplies in this chart.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision services" later in this section for more detail.	20% coinsurance for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies.[††] You pay these amounts until you reach the out-of-pocket maximum.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Medicare covers up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of pulmonary rehabilitation services.	$0 copayment for each Medicare-covered pulmonary rehabilitative visit.[††]
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening per year for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay when you get these services
qualified primary care doctor or practitioner in a primary care setting.	
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. **For LDCT lung cancer screenings after the initial LDCT screening:** the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	
Services to treat kidney disease Covered services include:	
•Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.	$0 copayment for Medicare-covered benefits.
•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)	20% coinsurance for Medicare-covered benefits.[††] You pay these amounts until you reach the out-of-pocket maximum.
•Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for Medicare-covered benefits.
•Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)	These services will be covered as described in the following sections: Please refer to Inpatient hospital care.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
•Home dialysis equipment and supplies	Please refer to Durable medical equipment and related supplies.
•Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	Please refer to Home health agency care.
Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 10 of this document. Skilled nursing facilities are sometimes called "SNFs.") Covered services include, but are not limited to: •Semiprivate room (or a private room if medically necessary) •Meals, including special diets •Skilled nursing services •Physical therapy, occupational therapy, and speech language therapy •Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) •Blood - including storage and administration. Coverage begins with the first pint of blood that you need. •Medical and surgical supplies ordinarily provided by SNFs •Laboratory tests ordinarily provided by SNFs	$0 copayment each day for Medicare-covered days 1 - 20. $203 copayment for additional Medicare-covered days, up to 100 days.†† You pay these amounts until you reach the out-of-pocket maximum. You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
•X-rays and other radiology services ordinarily provided by SNFs •Use of appliances such as wheelchairs ordinarily provided by SNFs •Physician/practitioner services A 3-day prior hospital stay is not required. Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. •A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). •A SNF where your spouse or domestic partner is living at the time you leave the hospital.	SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, we cover two counseling quit attempts within a 12-month period as a preventive service. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and have a referral from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must:	$0 copayment for each Medicare-covered supervised exercise therapy (SET) visit.[††]

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
• Consist of sessions lasting 30-60 minutes, comprising of a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider.	$40 copayment for each visit. $0 copayment for worldwide coverage of urgently needed services received outside of the United States. Please see Chapter 5 Section 1.1 for expense reimbursement for worldwide services. You pay these amounts until you reach the out-of-pocket maximum.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
Cost sharing for necessary urgently needed services furnished out-of-network in the United States is the same as for such services furnished in-network. Worldwide coverage for 'urgently needed services' when medical services are needed right away because of an illness, injury, or condition that you did not expect or anticipate, and you can't wait until you are back in our plan's service area to obtain services. Services provided by a dentist are not covered.	
Vision services Covered services include:	
• Outpatient physician services provided by an ophthalmologist or optometrist for the diagnosis and treatment of diseases and injuries of the eye, including diagnosis or treatment for age-related macular degeneration or cataracts. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.	$0 copayment for each Medicare-covered exam.[††]
• For people who are at high risk of glaucoma, we will cover 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.	$0 copayment for Medicare-covered glaucoma screening.
• For people with diabetes or signs and symptoms of eye disease, eye exams to evaluate for eye disease are covered per Medicare guidelines. Annual examinations by an ophthalmologist or optometrist are recommended for asymptomatic diabetics.	$0 copayment for Medicare-covered eye exams to evaluate for eye disease.[††]

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
•For people with diabetes, screening for diabetic retinopathy is covered once per year.	
•One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (additional pairs of eyeglasses or contacts are not covered by Medicare). If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery. Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any upgrades are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating).	$0 copayment for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.
Vision services - routine eye exam We cover 1 routine eye exam (eye refraction) every year You can get more information by viewing the Vendor Information Sheet at myUHCMedicare.com or by calling Customer Service to have a paper copy sent to you.	Provided by: UnitedHealthcare Vision® or plan network providers $0 copayment
Vision services - routine eyewear •1 pair of standard lenses and frames every year Standard lenses that are covered in full include single vision, lined bifocal, lined trifocal, lenticular, and Tier I (standard) progressive lenses. or •Contact lenses instead of lenses and frames every year Once contact lenses are selected and fitted, they may not be exchanged for eyeglasses.	Provided by: UnitedHealthcare Vision® $0 copayment Plan pays up to $100 toward your purchase of frames (with standard lenses covered in full) or contact lenses (fitting and evaluation may be an additional cost).

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services
The plan will pay up to the amount shown for covered eyeglasses or contact lenses. You are responsible for any costs after that. Options that are not covered include (but are not limited to) non-prescription eyewear, upgraded progressive lenses, blended bifocal, Hi Index, tinting, scratch coating, UV or anti-reflective coating, and polycarbonate. This benefit may not be combined with any in-store promotional offer, such as a 2-for-1 sale, discount, or coupon. You can get more information by viewing the Vendor Information Sheet at myUHCMedicare.com or by calling Customer Service to have a paper copy sent to you.	Home delivered eyewear is available nationwide through UnitedHealthcare Vision (select products only). You are responsible for all eyewear costs from providers outside of the UnitedHealthcare Vision network.
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this medical benefits chart. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. There is no coinsurance, copayment, or deductible for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" preventive visit. Please refer to outpatient diagnostic tests and therapeutic services and supplies for other EKG's.

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Services that are covered for you	What you must pay when you get these services

* Covered services that do not count toward your maximum out-of-pocket amount.

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

If you are a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits then your deductible, coinsurance and/or copayment may be less for services that are covered under Original Medicare.

Covered Routine Dental Benefits Included with Your Plan

- As part of your UnitedHealthcare Medicare Advantage plan you get a Routine Dental Benefit that provides coverage for the non-Medicare covered dental services described in detail below.
- Any services not listed below are NOT covered.
- This dental plan offers access to the robust UHC Dental National Medicare Advantage Network. Network dentists have agreed to provide services at a negotiated rate. If you see a network dentist, you cannot be billed more than that rate for covered services within the limitations of the plan. Any fees associated with non-covered services are your responsibility.
- For assistance finding a provider, please use the dental provider search tool at myUHCMedicare.com. You may also call 1-800-711-0646 for help with finding a provider or scheduling a dental appointment
- This dental plan offers both in-network and out-of-network dental coverage, and all covered services have $0 copayment. Out-of-network dentists are not contracted to accept plan payment as payment in full, so they might charge you for more than what the plan pays, even for services that have $0 copayment. Seeing a provider from the robust dental network can therefore result in substantial savings. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions.
- Some covered services may consider prior tooth history and procedures in conjunction with frequency limitations. If you wish to discuss detailed information about your plan with your dentist, you can find it in the UHC Dental Medicare quick reference guide at uhcmedicaredentalproviderqrg.com.
- When you have covered dental services performed at a network dentist, the dentist will submit the claim on your behalf. When you see an out-of-network dentist, often the dentist will submit a claim on your behalf. If they do not, then you can submit it directly using the following instructions:
    - The claim submission must contain the following information:
        - Full member name and member ID number
        - Full provider name and address
        - List of dental services rendered with the corresponding ADA code(s)
        - Proof of payment in the form of a receipt, check copy, EOB, or a ledger statement from the provider showing a positive payment against the services rendered
    - Mail all required claim information within 365 days from the date of service to: **P.O. Box 30567, Salt Lake City, UT 84130**

$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

  - Payment will be sent to the address listed on your account. To update your address or for assistance with submitting claims, contact Customer Service at 1-800-711-0646 TTY 711.
  - Claims are paid within 30 days and an Explanation of Payment (EOP) will accompany check payment
- Dentists may ask you to sign an informed consent document detailing the risks, benefits, costs, and alternatives to all recommended treatments. If you would like to learn more how your dental plan coverage relates to your proposed dental treatment and costs, you may ask your dentist to obtain a pre-treatment cost calculation from UHC Dental. If the provider has questions about how to obtain this information, they can contact UHC Dental using the number or website on the back of your Member ID card.
- For all other questions or more information, please call 1-800-711-0646 TTY 711 or visit myUHCMedicare.com

American Dental Association (ADA) codes:	Description of dental procedure:	Frequency:	Criteria and exclusions:	Copayment
Covered dental procedures are listed by ADA code. These codes are used by dentists to submit dental claims. Categories provide easy reference.	Easy to interpret description of the dental procedure code	How often UnitedHealthcare will pay for the dental procedure	Conditions under which UnitedHealthcare would pay for this procedure and situations where UnitedHealthcare would NOT pay for the procedure	*$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay.
Exams				
D0120	Routine periodic exam completed during check-up	2 procedures per plan year	Covers periodic, limited, comprehensive, and detailed/extensive oral exams. Does not cover periodontal exams separate from periodic, limited, or comprehensive exams. Only 1	$0*
D0150	Comprehensive exam (for a new patient, or an established patient after 3 or more years of inactivity from dental treatment)	1 procedure every 3 plan years		$0*

$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

American Dental Association (ADA) codes:	Description of dental procedure:	Frequency:	Criteria and exclusions:	Copayment
			exam code covered per appointment.	
X-rays				
D0210	Full-mouth/ complete X-ray set for evaluation of the teeth and mouth	1 procedure every 3 plan years	Covers intraoral complete series of radiographs. Does not cover CTs, cephalograms, or MRIs.	$0*
D0270, D0272, D0273, D0274, D0277	Bitewing X-rays for evaluation of the teeth and bone	1 procedure per plan year	Not covered in the same year as a full mouth set of X-rays (D0210)	$0*
D0330	Panoramic X-ray for evaluation of the teeth and mouth	1 procedure every 3 plan years	Covers panoramic radiographs. Does not cover CTs, cephalograms, or MRIs.	$0*
Cleanings				
D1110	Standard adult dental cleaning	2 procedures per plan year	Covers adult prophylaxis. Not covered on the same day as D4910 or D4355.	$0*

$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

American Dental Association (ADA) codes:	Description of dental procedure:	Frequency:	Criteria and exclusions:	Copayment
D4910	Routine dental cleaning for an adult who has documented history of gum disease	3 procedures per plan year	Covers periodontal maintenance. Only covered with history of scaling and root planing (deep cleaning) or periodontal surgery.	$0*
Other preventive services				
D1206, D1208	Fluoride	2 procedures per plan year	Covers topical application of fluoride (either varnish or excluding varnish).	$0*
D1310	Nutritional counseling	1 procedure per plan year	Covers counseling on dietary habits as a part of treatment and control of gum disease and/or cavities.	$0*
D1354	Application of medication to a tooth to stop or inhibit cavity formation	Unlimited per plan year	Covers application of interim caries arresting medicament-per tooth to a non-symptomatic carious tooth.	$0*

Exclusions:

1. Services performed by an out-of-network dentist if your plan does not have out-of-network coverage.
2. Dental services that are not necessary.

$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

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

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

$0 cost-share for network dental care, specified services only. If your plan offers out-of-network dental coverage and you see an out-of-network dentist you might be billed more, even for services listed as $0 copay. Benefits, features and/or devices vary by plan/area. Limitations and exclusions apply.

Section 2.2 Extra "optional supplemental" benefits you can buy

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called "**Optional Supplemental Benefits.**" If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

Adding Optional Supplemental Benefits to your plan

You must be enrolled in the plan in order to purchase an Optional Supplemental Rider. Purchasing an Optional Supplemental Rider is optional. You can purchase the rider at the time you enroll in your plan or within 3 months after the effective date of your plan.

Enrolling in Optional Supplemental Benefits

To enroll in an Optional Supplemental Rider, call Customer Service at the number listed on the cover. In general, completed requests to elect an Optional Supplemental Rider received by the last day of the month will be effective the first day of the following month.

Disenrolling from an Optional Supplemental Plan

If you wish to disenroll from an Optional Supplemental Rider, you may call Customer Service at the number listed on the cover.

Optional Supplemental Rider disenrollment requests received by the last day of the month will be effective the first day of the following month. Members will be responsible for their Optional Supplemental Rider premium payment for the following month if the disenrollment request is received after the last day of the current month. Disenrollment from an Optional Supplemental Rider will not result in disenrollment from your health plan.

Non-payment of plan premiums for an Optional Supplemental Rider will not result in disenrollment from your health plan, only the loss of the Optional Supplemental Rider and your return to the basic benefit plan.

If you have a procedure in progress at the time of your termination of your Rider, your Dental Office will complete the procedure. If we cancel your Dental Office's contract, or if your Dental Office cancels their contract with us, it will be our responsibility to see that you receive your Dental Benefits at another Dental Office.

Refund of Premium

Members enrolled in an Optional Supplemental Plan have a monthly plan premium and are entitled to a refund for any overpayments of plan premiums made during the course of the year or at the time of disenrollment. Overpayments of Optional Supplemental Plan premiums will be refunded as necessary or upon request or disenrollment. We will refund any overpayments within 30 business days of notification. We may apply your overpayment of Optional Supplemental benefit plan premiums to your monthly health plan premiums, if any.

Platinum Dental Rider

The Optional Supplemental Rider coverage described below is only applicable to Members who have enrolled into the dental rider and are paying the associated monthly premium.

If you have not already enrolled into this Optional Supplemental Rider and you would like to enroll in it, you should call the Customer Service number listed on the back cover of this booklet. You can enroll into the Rider at the time you enroll in your plan or within 3 months after the effective date of your plan. For members who stay on a plan from year to year your plan effective is January 1st of the plan year, therefore you can enroll into the rider during AEP for a January 1st effective date or within the first 3 months of that plan year.

Introducing the Platinum Dental Rider
We know that having choices in selecting health care benefits is important to you. The Platinum Dental Rider is an optional supplemental benefit package that can be purchased to replace any dental benefits that may already be offered within your Medicare Advantage plan. **The Platinum Dental Rider cannot be combined with any other dental benefits that may be included in your plan. It is offered to you for a monthly premium of $56.00.** This is in addition to any plan premium you may have for your Medicare Advantage plan.

Covered Platinum Dental Rider Benefits:
Annual Maximum: $1,500

- As a part of the Platinum Dental Rider you get coverage for non-Medicare covered preventive and other necessary dental services such as:
  - Exams
  - Cleanings (Prophylaxis, Periodontal Maintenance, & Deep Cleanings)
  - X-rays
  - Fillings
  - Crowns
  - Bridges
  - Root Canals
  - Extractions
  - Partial Dentures
  - Complete Dentures
- $0 copay for preventive and diagnostic dental care such as exams, routine cleanings, x-rays, and fluoride.
- A 50% coinsurance applies to dentures and bridges (coinsurance applies to the actual dentures and bridges, not to modifications and adjustments for existing dentures or bridges).
- All other covered comprehensive services are offered at a $0 copay (including modification and adjustments to dentures and bridges).
- Some covered services may consider prior tooth history and procedures in conjunction with frequency limitations. If you wish to discuss detailed information about your plan with your dentist or see the full list of covered dental services with associated frequency limitations, you can find it in the UHC Dental Medicare quick reference guide at uhcmedicaredentalproviderqrg.com
- Procedures used for cosmetic-only reasons (tooth bleaching/whitening, veneers, gingival recontouring, enamel microabrasion), orthodontics, space maintenance, implants and implant-

related services, sales tax, charges for failure to keep appointments, dental case management, dental charges related to COVID screening, testing and vaccination, and unspecified procedures by report are not covered by the plan.

- After the annual maximum is exhausted, any remaining charges are your responsibility. Other limitations and exclusions are listed below.
- This dental plan offers access to the robust UHC Dental National Medicare Advantage Network. Network dentists have agreed to provide services at a negotiated rate. If you see a network dentist, you cannot be billed more than that rate for covered services within the limitations of the plan. Any fees associated with non-covered services are your responsibility.
- For assistance finding a provider, please use the dental provider search tool at myUHCMedicare.com. You may also call 1-800-711-0646 for help with finding a provider or scheduling a dental appointment
- This dental plan offers both in-network and out-of-network dental coverage. Out-of-network dentists are not contracted to accept plan payment as payment in full, so they might charge you for more than what the plan pays, even for services that have $0 copayment. Seeing a provider from the robust dental network can therefore result in substantial savings. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions.
- When you have covered dental services performed at a network dentist, the dentist will submit the claim on your behalf. When you see an out-of-network dentist, often the dentist will submit a claim on your behalf. If they do not, then you can submit it directly using the following instructions:
  - The claim submission must contain the following information:
    - Full member name and member ID number
    - Full provider name and address
    - List of dental services rendered with the corresponding ADA code(s)
    - Proof of payment in the form of a receipt, check copy, EOB, or a ledger statement from the provider showing a positive payment against the services rendered
  - Mail all required claim information within 365 days from the date of service to: **P.O. Box 30567, Salt Lake City, UT 84130**
  - Payment will be sent to the address listed on your account. To update your address or for assistance with submitting claims, contact Customer Service at 1-800-711-0646 TTY 711.
  - Claims are paid within 30 days and an Explanation of Payment (EOP) will accompany check payment
- Dentists may ask you to sign an informed consent document detailing the risks, benefits, costs, and alternatives to all recommended treatments. If you would like to learn more how your dental plan coverage relates to your proposed dental treatment and costs, you may ask your dentist to obtain a pre-treatment cost calculation from UHC Dental. If the provider has questions about how to obtain this information, they can contact UHC Dental using the number or website on the back of your Member ID card.
- For all other questions or more information, please call 1-800-711-0646 TTY 711 or visit myUHCMedicare.com

Recovery of Payments

We reserve the right to deduct from any benefits properly payable under the Platinum Dental Rider the amount of any payment that has been made:

1. In error
2. Due to a misstatement contained in a claim
3. Due to a misstatement made to get coverage
4. With respect to an ineligible person; this deduction may be made against any claim for benefits under the Dental Rider by you if such payment is made with respect to you. No request for a refund of all or a portion of a payment of a claim to you or to a dentist will be made after 24 months from the claim payment date. The only exceptions to this are when the payment was made because of fraud committed by you or the dentist, or if you or the dentist has otherwise agreed to make a refund for overpayment of a claim.

Discharge of Liability

Any payment made in accordance with the provisions of the Platinum Dental Rider shall fully discharge our liability to the extent of such payment.

Exclusions:

1. Services performed by an out-of-network dentist if your plan does not have out-of-network coverage.
2. Dental services that are not necessary.
3. Hospitalization or other facility charges.
4. Any dental procedure performed solely for cosmetic and/or aesthetic reasons.
5. Any dental procedure not directly associated with a dental disease.
6. Any procedure not performed in a dental setting.
7. Reconstructive surgery of any type, including reconstructive surgery related to a dental disease, injury, or congenital anomaly.
8. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on dental therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.

9. Service for injuries or conditions covered by workmen's compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county, or other political subdivision. This exclusion does NOT apply to any services covered by Medicaid or Medicare.
10. Expenses for dental procedures begun prior to the covered person’s eligibility with the plan.
11. Dental services rendered (including otherwise covered dental services) after the date on which individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date on which individual coverage under the policy terminates.

12. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.
13. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice, sales tax, or duplicating/copying patient records.
14. Implants and implant-related services.
15. Tooth bleaching and/or enamel microabrasion
16. Veneers
17. Orthodontics
18. Sustained release of therapeutic drug (D9613)
19. COVID screening, testing, and vaccination
20. Charges aligned to dental case management, case presentation, consultation with other medical professionals or translation/sign language services.
21. Space Maintenance
22. Any unspecified procedure by report (Dental codes: D##99)

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

Section 3 What services are not covered by the plan?

Section 3.1 Services we do not cover (exclusions)

This section tells you what services are “excluded” from Medicare coverage and therefore, are not covered by this plan.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

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

The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary,	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
according to Original Medicare standards.		
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	Not covered under any condition	
Full-time nursing care in your home.	Not covered under any condition	
Custodial care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	Not covered under any condition	
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition	
Cosmetic surgery or procedures.		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Chiropractic services (Medicare-covered)		Manual manipulation of the spine to correct a subluxation is covered. Excluded from Medicare coverage is any service other than manual manipulation of the spine for the treatment of subluxation.
Non-routine dental care.		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet.		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease. (As specifically described in the medical benefits chart in this chapter.)
Outpatient prescription drugs.		Some coverage provided according to Medicare guidelines. (As specifically described in the medical benefits chart in this chapter.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Elective hysterectomy, tubal ligation, or vasectomy, if the primary indication for these procedures is sterilization. Reversal of sterilization procedures, penile vacuum erection devices, or non-prescription contraceptive supplies.	Not covered under any condition	
Acupuncture (Medicare-covered).		Available for people with chronic low back pain under certain circumstances. (As specifically described in the medical benefits chart in this chapter.)
Naturopath services (uses natural or alternative treatments).	Not covered under any condition	
Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport)		Services are only covered when the ambulance pick-up address is located in rural New York and applicable conditions are met. Members are responsible for all paramedic intercept service costs that occur outside of rural New York.
Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including but not limited to home and car remodeling or modification, and exercise equipment.	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Immunizations for foreign travel purposes.	Not covered under any condition	
Equipment or supplies that condition the air, heating pads, hot water bottles, wigs and their care, support stockings and other primarily non-medical equipment.	Not covered by Medicare under any condition	Disposable or nonreusable items such as incontinence supplies are not covered under Medicare but may be covered under the OTC benefit.
Any non-emergency care received outside of the United States and the U.S. Territories.	Not covered under any condition	
For transplants: items not covered include, but are not limited to the below. For transportation: •Vehicle rental, purchase, or maintenance/repairs •Auto clubs (roadside assistance) •Gas •Travel by air or ground ambulance (may be covered under your medical benefit). •Air or ground travel not related to medical appointments •Parking fees incurred other than at lodging or hospital For lodging: •Deposits •Utilities (if billed separate from the rent payment) •Phone calls, newspapers, movie rentals and gift cards	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
•Expenses for lodging when staying with a relative or friend •Meals		

We regularly review new procedures, devices and drugs to determine whether or not they are safe and effective for members. New procedures and technology that are safe and effective are eligible to become covered services. If the technology becomes a covered service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safe and effective use of a new technology or new application of an existing technology for an individual member, one of our medical directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

Chapter 5

Asking us to pay our share of a bill you have received for covered medical services

Section 1 Situations in which you should ask us to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In these cases, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

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

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

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

   Outside the service area, you can receive emergency or urgently needed services from any provider in the United States, whether or not the provider is a part of our network. In these cases, you are only responsible for paying your share of the cost. Ask the provider to bill the plan for our share of the cost.

   - If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we will pay the provider directly.
     - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. **When a network provider sends you a bill you think you should not pay**

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

   - You only have to pay your cost-sharing amount when you get covered services. We do not allow network providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay

the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

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

3. If you are retroactively enrolled in our plan

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

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

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

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

- Pay your bill at the time it is received. We will reimburse you for the difference between the amount of your bill and your cost share for the services as outlined in Chapter 4 of this document.
- Save all of your receipts and send us copies when you ask us to pay you back. In some situations, we may need to get more information from you or the provider who rendered services to you in order to pay you back for our share of the cost. Please see Chapter 5 Section 2.1 for expense reimbursement for worldwide services.
- If you are being asked to pay your bill for worldwide emergency services and are unable to make the payment, please call Customer Service for additional assistance and we may be able to help coordinate payment for covered services on your behalf.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

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

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

To make sure you 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 don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (**myUHCMedicare.com**) or call Customer Service and ask for the form.

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

  Medical claims payment requests:
  UnitedHealthcare
  P.O. Box 31362
  Salt Lake City, UT 84131-0362

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

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

Section 3.1 We check to see whether we should cover the service and how much we owe

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

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

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7 of this document.

Chapter 6

Your rights and responsibilities

Section 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service.

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

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

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

Sección 1.1 Usted tiene derecho a recibir información sobre la organización, sus servicios, sus profesionales del cuidado de la salud y proveedores, además de los derechos y las responsabilidades de los miembros. Debemos brindarle información útil y en otros idiomas aparte del inglés, en braille, en letras grandes o en otros formatos alternativos

Para recibir información nuestra de una forma que le resulte conveniente, llame a Servicio al Cliente (los números de teléfono aparecen en la portada de esta guía).

Nuestro plan cuenta con personas y servicios gratuitos de intérpretes para responder las preguntas de los miembros discapacitados y los que no hablan inglés. Esta información está disponible sin costo en otros idiomas. También podemos proporcionarle información en braille, en letras grandes o en otros formatos alternativos sin costo, si es necesario. Se nos exige que le proporcionemos la información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para recibir información nuestra de una forma que le resulte conveniente, llame a Servicio al Cliente (los números de teléfono aparecen en la portada de esta guía) o comuníquese con nuestro Coordinador de Derechos Civiles.

Si tiene alguna dificultad para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llame a Servicio al Cliente para presentar una queja formal (los números de teléfono aparecen en la portada de esta guía). También puede presentar una queja ante Medicare si llama al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles. La información de contacto se incluye en esta **Evidencia de Cobertura** o con esta correspondencia o, para obtener información adicional, puede comunicarse con Servicio al Cliente.

Section 1.2 We must ensure that you get timely access to your covered services

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

You have the right to get appointments and covered services from the plan's network of providers, **within a reasonable amount of time**. This includes the right to get timely services from specialists when you need that care.

How to Receive Care After Hours

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

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

HEALTH PLAN NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024

We[1] are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice that is currently in effect.

The terms "information" or "health information" in this notice include information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the

requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to confirm we are meeting our privacy obligations.

We may collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may collect, use, and disclose your health information:

- **For Payment** of premiums owed to us, to determine your health care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment**, including to aid in your treatment or the coordination of your care. For example, we share information with other doctors to help them provide medical care to you.
- **For Health Care Operations** as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.
- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors,** if your coverage is through an employer sponsored group health plan. We may share summary health information and enrollment and disenrollment information with the plan sponsor. We also may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

- **For Underwriting Purposes;** however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information in risk rating and pricing such as age and gender, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders,** we may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment or health care operations using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances and subject to certain requirements:

- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who help pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements, or for certain activities related to preparing a research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Donation Purposes** to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information.
- **Additional Restrictions on Use and Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. Such laws may protect the following types of information:

    1. Alcohol and Substance Use Disorder
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

We will follow the more stringent and protective law, where it applies to us.

Except for uses and disclosures described in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for

certain marketing communications, without your written authorization. Once you give us authorization to use or disclose your health information, you may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. For information on how to revoke your authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Any request for restrictions must be made in writing. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any request for a restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to request to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send a copy of your health information in an electronic format to you. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; (iii) to correctional institutions or law enforcement officials; and

(iv) other disclosures for which federal law does not require us to provide an accounting. Any request for an accounting must be made in writing.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your website.
- **In certain states, you may have the right to request that we delete** your personal information. Depending on your state of residence, you may have the right to request deletion of your personal information. We will respond to your request in the timeframe required under applicable law. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about how to exercise your rights, **please call the toll-free member phone number on your health plan ID card or you may contact a UnitedHealth Group Customer Call Center Representative at 1-800-711-0646 (TTY/RTT 711).**
- **Submitting a Written Request.** To exercise any of your rights described above, mail your written requests to us at the following address:

  UnitedHealthcare
  Customer Service - Privacy Unit
  PO Box 740815
  Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

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

[1]This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2024

We[2] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-800-711-0646 (TTY 711).**

[2] For purposes of this Financial Information Privacy Notice, “we” or “us” refers to health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc; OptumHealth Care Solutions, LLC; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holding, 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 for HIPAA covered entities or health insurance products. For a current list of entities subject to this notice go to www.uhc.com/privacy/entities-fn-v1

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

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

- **Information about our plan**. This includes, for example, information about the plan’s financial condition.
- **Information about our network providers**.
  - You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.

- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have a right to participate with practitioners in making decisions about your health care. We must support your right to make decisions about your care and a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

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

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

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

- **To know about all of your choices**. You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks**. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

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

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

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

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

- **Get the form**. You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service for assistance in locating an advanced directive form.
- **Fill it out and sign it**. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people**. You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you 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 whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What 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 3 for contact information regarding your state-specific agency.

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

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do.

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

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, **and** it's **not** about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service**.
- You can **call the SHIP.** For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

There are several places where you can get more information about your rights:

- You can **call Customer Service**.
- For information on the quality program for your specific health plan, call Customer Service. You may also access this information via the website (uhcmedicaresolutions.com/resources/ma-pdp-information-forms.html). Select, "Commitment to Quality."
- You can **call the SHIP.** For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this **Evidence of Coverage** to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your UnitedHealthcare member ID card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**

  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate**. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
  - You must continue to pay your Medicare Part B premium to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
  - **If you move outside of our plan service area, you cannot remain a member of our plan**.
  - **If you move within our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

Chapter 7

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

Section 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

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

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

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

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

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

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

Section 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

Section 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

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

Yes.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

No.

Skip ahead to **Section 9** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

Coverage decisions and appeals

Section 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as medical care. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical

specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision. When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules.

When we have completed the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See Section 5.4 of this chapter for more information about Level 2 appeals.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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

- You **can call us at Customer Service**.
- You can get free help from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
  - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or another person to be your representative, call Customer Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf .) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon"
- **Section 7** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (**Applies only to these services:** home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Service. You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

Section 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: **Medical Benefits Chart (what is covered and what you pay)**. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms	When a coverage decision involves your medical care, it is called an **"organization determination."**

A “fast coverage decision” is called an **“expedited determination.”**

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

A “standard coverage decision” is usually made within 14 days or 72 hours for Part B drugs. A “fast coverage decision” is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may **only ask** for coverage for medical items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision **only** if using the standard deadlines **could cause serious harm to your health or hurt your ability to function.**
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision**. If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

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

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

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. 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". We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 9 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. 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." (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

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

Section 5.3 Step-by-step: How to make a Level 1 appeal

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

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

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

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.2 of this chapter.

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

- **If you are asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us**. Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

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

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.

  - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a "standard appeal"

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. 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 more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. 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". When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 9 of this chapter for information on complaints.)
  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- If our plan says no to part or all of your appeal, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

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

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

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

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

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

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

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

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

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

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal,** it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.") In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

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

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive

your request. If you haven't paid for the medical care, we will send the payment directly to the provider.

- **If we say no to your request:** If the medical care is **not** covered, or you did **not** follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

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

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

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

Section 6 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

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

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

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

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

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

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.
3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Section 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

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

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

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge.**
  - If you meet this deadline, you may stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.
  - If you do **not** meet this deadline, 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 receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service 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 you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 6.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

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

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

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said **no** to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

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

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

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

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

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

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

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

Legal Term	A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, **the first two levels of appeal are different**.

Step-by-Step: How to make a Level 1 alternate appeal

Step 1: Contact our plan and ask for a "fast review."

- **Ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a "fast review".

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of 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 received after the planned discharge date.

Step 4: If our plan says no to your appeal, your case will automatically be sent on to the next level of the appeals process.

Step-by-Step: Level 2 alternate appeal process

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

The independent review organization is an independent organization hired by Medicare. It is not connected with our plan and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the Independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.

- **If this organization says yes to your appeal,** then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
  - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

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

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

Section 7.2 We will tell you in advance when your coverage will be ending

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

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   – The date when we will stop covering the care for you.
   – How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

Section 7.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

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

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

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you received (Notice of Medicare Non-Coverage) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

Legal Term	**"Detailed Explanation of Non-Coverage."** Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review the information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say **yes** to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say **no**, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

- If reviewers say **no** to your Level 1 appeal – **and** you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

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

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said **no** to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

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

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

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, **the first two levels of appeal are different**.

Step-by-Step: How to make a Level 1 Alternate Appeal

Legal Term	A “fast” review (or “fast appeal”) is also called an **“expedited appeal.”**

Step 1: Contact us and ask for a “fast review.”

- **Ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines. Chapter 2 has contact information.

Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a "fast review".

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.

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

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your "fast appeal." This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

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

- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal: An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
  - If we decide **not** to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal: The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process may or may not be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

  – If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal: A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

Section 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is only used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	•Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	•Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	•Has someone been rude or disrespectful to you? •Are you unhappy with our Customer Service? •Do you feel you are being encouraged to leave the plan?
Waiting times	•Are you having trouble getting an appointment, or waiting too long to get it? •Have you been kept waiting too long by doctors or other health professionals? Or by Customer Service or other staff at our plan? – Examples include waiting too long on the phone, in the waiting or exam room.
Cleanliness	•Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Complaint	Example
Information you get from us	•Did we fail to give you a required notice? •Is our written information hard to understand?
Timeliness (These types of complaints are all related to the **timeliness** of our actions related to coverage decisions and appeals)	If you have asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: •You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. •You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. •You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint. •You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms	A **"complaint"** is also called a **"grievance."** **"Making a complaint"** is also called **"filing a grievance."** **"Using the process for complaints"** is also called **"using the process for filing a grievance."** A **"fast complaint"** is also called an **"expedited grievance."**

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

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

  If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. The address and fax numbers for filing complaints are located in Chapter 2 under "How to contact us when you are making a complaint about your medical care."
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint".** If you have a "fast complaint," it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about **quality of care**, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization**.
- The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Chapter 8

Ending your membership in the plan

Section 1 Introduction to ending your membership in our plan

Ending your membership in the plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you **want** to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and you will continue to pay your cost share until your membership ends.

Section 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
- Another Medicare health plan, with or without prescription drug coverage.
- Original Medicare **with** a separate Medicare prescription drug plan.
- Original Medicare without a separate Medicare prescription drug plan.
- Your membership will end in our plan when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make **one** change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.

- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (medicare.gov):

- Usually, when you have moved.
- If you have Medicaid.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE). * PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service (phone numbers are printed on the cover of this booklet).

Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare with a separate Medicare prescription drug plan.
- **– or–** Original Medicare **without** a separate Medicare prescription drug plan.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Customer Service.**
- Find the information in the **Medicare & You 2024** handbook.

- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

Section 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
• Original Medicare **with** a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
• Original Medicare without a separate Medicare prescription drug plan.	• **Send us a written request to disenroll** or visit our website to disenroll online. Contact Customer Service if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from our plan when your coverage in Original Medicare begins.

Note: If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

Section 4 Until your membership ends, you must keep getting your medical items, services through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical items, services care through our plan.

- **Continue to use our network providers to receive medical care.**

- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).**

Section 5 We must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

We must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than 6 months.
  - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan's area .
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- 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. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your UnitedHealthcare member ID card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Customer Service.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

Our plan is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

Chapter 9
Legal notices

Section 1 Notice about governing law

The principal law that applies to this **Evidence of Coverage** document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

Section 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

Section 4 Third party liability and subrogation

If you suffer an illness or injury for which any third party is alleged to be liable or responsible due to any negligent or intentional act or omission causing illness or injury to you, you must promptly notify us of the illness or injury. We will send you a statement of the amounts we paid for services provided in connection with the illness or injury. If you recover any sums from any third party, we shall be reimbursed out of any such recovery from any third party for the payments we made on your behalf, subject to the limitations in the following paragraphs.

1) **Our payments are less than the recovery amount**. If our payments are less than the total recovery amount from any third party (the "recovery amount"), then our reimbursement is computed as follows:
   a) **First**: Determine the ratio of the procurement costs to the recovery amount (the term "procurement costs" means the attorney fees and expenses incurred in obtaining a settlement or judgment).
   b) **Second**: Apply the ratio calculated above to our payment. The result is our share of procurement costs.
   c) **Third**: Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.
2) **Our payments equal or exceed the recovery amount**. If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.
3) **We incur procurement costs because of opposition to our reimbursement.** If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
   a) Our payments made on your behalf for services; or
   b) the recovery amount, minus the party's total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment or verdict. You may be required by us and you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

Section 5 Member liability

In the event we fail to reimburse provider's charges for covered services, you will not be liable for any sums owed by us. Neither the plan nor Medicare will pay for non-covered services except for the following eligible expenses:

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

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

Section 6 Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your plan, unless otherwise listed as a covered service. A service is "reasonable and necessary" if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
  2. Furnished in a setting appropriate to the patient's medical needs and condition;
  3. Ordered and furnished by qualified personnel;
  4. One that meets, but does not exceed, the patient's medical need; and
  5. At least as beneficial as an existing and available medically appropriate alternative.

Section 7 Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership**.

Section 8 Acts beyond our control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any provider shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

Section 9 Contracting medical providers and network hospitals are independent contractors

The relationships between the plan and network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of the plan. An agent would be anyone authorized to act on the plan's behalf.

Section 10 Technology assessment

We regularly review new procedures, devices and drugs to determine whether or not they are safe and efficacious for members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable member copayments, coinsurance, deductibles or other payment contributions.

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual member, one of our Medical Directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

Section 11 Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered services under this Evidence of Coverage or be used in defense of a legal action unless it is contained in a written application.

Section 12 Information upon request

As a plan member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality improvement programs
- Statistical data on grievances and appeals
- The financial condition of UnitedHealthcare Insurance Company or one of its affiliates

Section 13 2024 Enrollee Fraud & Abuse Communication

2024 Enrollee Fraud & Abuse Communication
How you can fight healthcare fraud

Our company is committed to preventing fraud, waste, and abuse in Medicare benefit programs and we're asking for your help. If you identify a potential case of fraud, please report it to us immediately.
Here are some examples of potential Medicare fraud cases:

- A health care provider - such as a physician, or medical device company - bills for services you never got;
- A supplier bills for equipment different from what you got;
- Someone uses another person's Medicare card to get medical care, supplies or equipment;
- Someone bills for home medical equipment after it has been returned;
- A company offers a Medicare drug or health plan that hasn't been approved by Medicare; or
- A company uses false information to mislead you into joining a Medicare drug or health plan.

To report a potential case of fraud in a Medicare benefit program, call UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) Customer Service at 1-800-711-0646 (TTY 711), 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization will not take any action against you for reporting a potential fraud case in good faith.

You may also report potential medical or prescription drug fraud cases to the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SafeRx (1-877-772-3379) or to the Medicare program directly at (1-800-633-4227). The Medicare fax number is 1-717-975-4442 and the website is medicare.gov.

Section 14 Commitment of Coverage Decisions

UnitedHealthcare's Clinical Services Staff and Physicians make decisions on the health care services you receive based on the appropriateness of care and service and existence of coverage. Clinical Staff and Physicians making these decisions: 1. Do not specifically receive reward for issuing non-coverage (denial) decisions; 2. Do not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services; and 3. Do not hire, promote, or terminate physicians or other individuals based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Section 15 Renew Active® Terms and Conditions

Eligibility requirements

- Only members enrolled in a participating Medicare Plan insured by UnitedHealthcare Insurance Company ("UnitedHealthcare") and affiliates are eligible for the Renew Active program ("Program"), which includes, without limitation, access to standard fitness memberships at

participating gyms/fitness locations, online fitness and cognitive providers, digital communities, in-person and virtual events, clubs, classes and discounts for meal delivery at no additional cost.

- By enrolling in the Program, you hereby accept and agree to be bound by these terms and conditions.

Enrollment requirements

- Membership and participation in the Program is voluntary.
- You must enroll in the Program according to the instructions provided on this website. Once enrolled, you must obtain your confirmation code and provide it when requested to sign up for any Program services. Provide your confirmation code when requested when visiting a participating gym/fitness location to receive standard membership access at no additional cost, registering with an online fitness and/or cognitive providers, joining the Fitbit® Community for Renew Active, and to gain access to included discounts. Please note, that by using your confirmation code, you are electing to disclose that you are a Renew Active member with a participating UnitedHealthcare Medicare plan.
- Program enrollment is on an individual basis and the Program's waived monthly membership rate for standard membership services at participating gyms and fitness locations is only applicable to individual memberships.
- You are responsible for any and all non-covered services and/or similar fee-based products and services offered by Program service providers (including, without limitation, gym/fitness centers, digital fitness offerings, digital cognitive providers, Fitbit, and other third party service offerings made available through the Program), including, without limitation, fees associated with personal training sessions, specialized classes, enhanced facility membership levels beyond the basic or standard membership level, and meal delivery.

Fitness membership equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Access to gym and fitness location network may vary by location and plan.

Liability waiver

- Always seek the advice of a doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine.
- Certain services, discounts, classes, events, and online fitness offerings are provided by affiliates of UnitedHealthcare or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services are subject to your acceptance of their respective terms and policies. UnitedHealthcare and its respective subsidiaries are not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. UnitedHealthcare and its respective subsidiaries and affiliates do not endorse and are not responsible for the services or information provided by third parties, the content on any linked site, or for any injuries you may sustain while participating in any activities under the Program.

Other requirements

- You must verify that the individual gym/fitness location or service provider participates in the Program before enrolling.
- If a Program service provider you use, including a gym or fitness location, ceases to participate in the Program, your Program participation and waived monthly membership rate with such service provider through the Program will be discontinued until you join another service offered by a participating service provider. You will be responsible for paying the standard membership rates of the service provider should you elect to continue to receive services from a service provider once that service provider ceases to participate in our Program. If you wish to cancel your membership with such service provider, you can opt to do so per the cancellation policy of the applicable service provider, including the applicable gym or fitness location. You should review your termination rights with a service provider when you initially elect to sign up with such service provider.

Data requirements

- Optum (the Program administrator) and/or your service provider will collect and electronically send and/or receive the minimum amount of your personal information required in order to facilitate the Program in accordance with the requirements of applicable laws, including privacy laws. Such required personal information includes, but is not limited to, program confirmation code, gym/fitness location/provider membership ID, activity year and month, and monthly visit count. By enrolling in the Program, you authorize Optum and your service provider to request and/or provide such personal information.

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Chapter 10

Definitions of important words

Chapter 10

Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period –The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS), you only have to pay our plan's allowed cost-sharing amounts when you get services covered by our plan. We do not allow network providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Clinical Research Study – A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services. Coinsurance for in-network services is based upon contractually negotiated rates (when available for the specific covered service to which the coinsurance applies) or Medicare Allowable Cost, depending on our contractual arrangements for

the service.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription . A copayment is a set amount (for example $10), rather than a percentage.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service that a plan requires when a specific service is received.

Covered Services – The term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or

hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare or a state program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

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 (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Chapter 4, Section 2.1 under the heading “Home health agency care.” If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren’t covered unless you are also getting a covered skilled service. Home health services don’t include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit medicare.gov and under “Search Tools” choose “Find a Medicare Publication” to view or download the publication “Medicare Hospice Benefits.” Or, call (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day/7 days a week.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums and Medicare Part A and Part B premiums, do not count toward the maximum out-of-pocket amount. See Chapter 4, Section **1.2** for information about your maximum out-of-pocket amount

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) does not offer Medicare prescription drug coverage.

Medicare Allowable Cost – The maximum price of a service for reimbursement purposes under Original Medicare.

Medicare Assignment – In Original Medicare, a doctor or supplier "accepts assignment" when he or she agrees to accept the Medicare-approved amount as full payment for covered services.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 1, Section 3.2)

Network Provider – "Provider" is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. "Network providers" have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service.

Part C – see **"Medicare Advantage (MA) Plan."**

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Point of Service (POS) Plan – As a member of this Point of Service (POS) plan you may receive covered services from network providers. You may also receive covered routine dental services from providers who are not contracted with UnitedHealthcare.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health coverage.

Prescription Drug Benefit Manager – Third party prescription drug organization responsible for processing and paying prescription drug claims, developing and maintaining the drug list (formulary), and negotiating discounts and rebates with drug manufacturers.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – For medical services it means a process where your PCP or treating provider must receive approval in advance before certain medical services will be provided or payable. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Provider – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Retail Walk-In Clinic – A provider location that generally does not require appointments and may be a standalone location or located in a retail store, supermarket or pharmacy. Walk-In Clinic

Services are subject to the same cost-sharing as Urgent Care Centers. (See the Benefit Chart in Chapter 4)

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

UHC Medicare Advantage Patriot No Rx CT-MA01 (HMO-POS) Customer Service:

Call **1-800-711-0646**

Calls to this number are free. 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept. Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**

Calls to this number are free. 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

Write: **P.O. Box 30770**
Salt Lake City, UT 84130-0770

myUHCMedicare.com

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.
You can call the SHIP in your state at the number listed in Chapter 2 Section 3 of the Evidence of Coverage.

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