



Evidence of Coverage 2023

UnitedHealthcare Dual Complete® ONE (HMO D-SNP)



Toll-free **1-800-514-4911**, TTY **711**
8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept.



myuhc.com/CommunityPlan

United
Healthcare
Community Plan

January 1–December 31, 2023

Evidence of coverage

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of UnitedHealthcare Dual Complete® ONE (HMO D-SNP)

This document gives you the details about your Medicare and Medicaid health care, long-term care, home and community-based services and prescription drug coverage from January 1–December 31, 2023.



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

For questions about this document, please contact Customer Service at 1-800-514-4911. (TTY users should call 711). Hours are 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept.

This plan, UnitedHealthcare Dual Complete® ONE (HMO D-SNP), is offered by UnitedHealthcare or one of its affiliates. (When this **Evidence of Coverage** says “we,” “us,” or “our,” it means UnitedHealthcare or one of its affiliates. When it says “plan” or “our plan,” it means UnitedHealthcare Dual Complete® ONE (HMO D-SNP).

UnitedHealthcare Dual Complete ONE (HMO D-SNP) is a Dual Eligible Special Needs Plan (D-SNP) with a Medicare contract and a contract with the New Jersey Medicaid program. Enrollment in UnitedHealthcare Dual Complete ONE depends on contract renewal. This plan is available to anyone who has both Medicare and full New Jersey Medicaid benefits.

This document is available for free in Spanish.

Este documento está disponible sin costo en español. Comuníquese con nuestro número de Servicio al Cliente al **1-800-514-4911** para obtener información adicional. (Los usuarios de TTY deben llamar al **711**). El horario de atención es de 8 a.m. a 8 p.m.: los 7 días de la semana, de octubre a marzo; de lunes a viernes, de abril a septiembre.

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

We provide free services to help you communicate with us such as letters in other languages, braille, large print, audio. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

Benefits may change on January 1, 2024.

The formulary, pharmacy network, and/or 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.

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

Participation in the Renew Active® by UnitedHealthcare program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership. Equipment, classes, personalized fitness plans, and events may vary by location. Certain services, classes and events are provided by affiliates of UnitedHealthcare Insurance Company 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 is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. Gym network may vary in local market.

Members must use network plan providers, pharmacies, DME (Durable Medical Equipment) suppliers, and follow the rules on referrals.

Members will be enrolled into Medicare Part D prescription drug coverage under the plan and will be automatically disenrolled from any other Medicare Advantage or Medicare Part D prescription drug coverage.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare Dual Complete ONE members, except in emergency situations.

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

- Your medical and prescription drug 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.

Benefits vary by plan/area. Limitations and exclusions apply.

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Chapter 1

Getting started as a member

Section 1 Introduction

Section 1.1 You are enrolled in UnitedHealthcare Dual Complete® ONE (HMO D-SNP), which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and Medicaid:

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, UnitedHealthcare Dual Complete® ONE (HMO D-SNP). We are required to cover all Part A and Part B services. However, provider access in this plan differs from Original Medicare.

UnitedHealthcare Dual Complete® ONE (HMO D-SNP) is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. UnitedHealthcare Dual Complete® ONE (HMO D-SNP) is designed for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you are eligible for full Medicaid benefits you will pay nothing for your Medicare health care services. Medicaid also provides other benefits to you by covering health care services including long-term care and home and community-based services, as well as prescription drugs that are not usually covered under Medicare. UnitedHealthcare Dual Complete® ONE (HMO D-SNP) will help manage all of these benefits for you, so that you get the health care services that you are entitled to.

UnitedHealthcare Dual Complete® ONE (HMO D-SNP) is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the New Jersey Medicaid program, to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including long-term care and home and community-based services, as well as your 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](https://www.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 as well as long-term care and home- and community-based services and prescription drugs. 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 word “coverage” and “covered services” refers to the medical care and services as well as long-term care and home- and community-based services and the prescription drugs available to you as a member of UnitedHealthcare Dual Complete® ONE (HMO D-SNP).

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 UnitedHealthcare Dual Complete® ONE (HMO D-SNP) covers your care. Other parts of this contract include your enrollment form, the **List of Covered Drugs (Formulary)**, 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 UnitedHealthcare Dual Complete® ONE (HMO D-SNP) between January 1, 2023 and December 31, 2023.

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 UnitedHealthcare Dual Complete® ONE (HMO D-SNP) after December 31, 2023. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2023.

Medicare (the Centers for Medicare & Medicaid Services), as well as the New Jersey Medicaid program, must approve UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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 and the New Jersey Medicaid program renew their 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 2.3 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.
- — **and** — You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

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

Please note: If you lose your Medicaid eligibility but can reasonably be expected to regain eligibility within six month(s), then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage during a period of deemed continued eligibility).

Section 2.2 What is Medicaid?

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

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary Plus (QMB+):** Pays Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and co-payments), and includes eligibility for full Medicaid benefits.

Section 2.3 Here is the plan service area for UnitedHealthcare Dual Complete® ONE (HMO D-SNP)

UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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 New Jersey: Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren.

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 2.4 U.S. Citizen or Lawful Presence

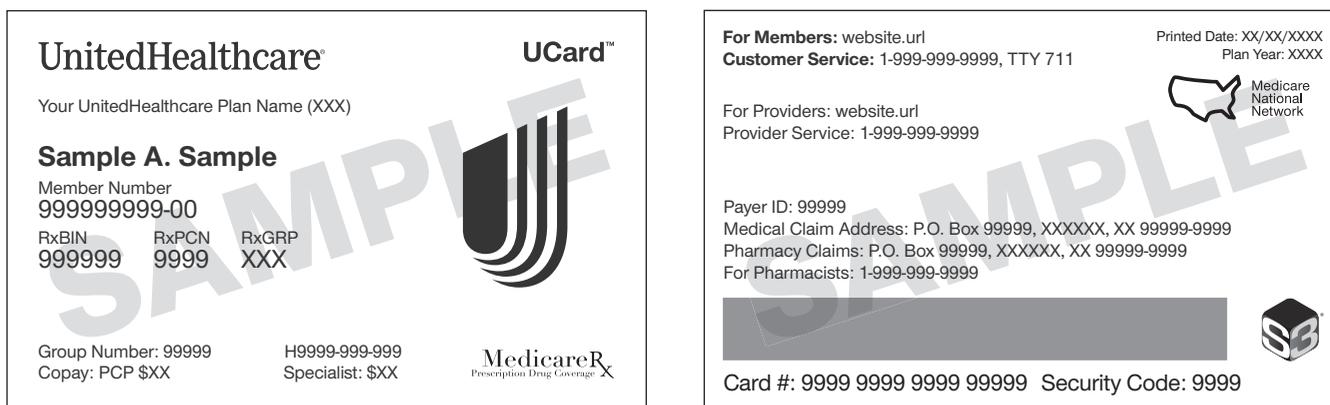
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify UnitedHealthcare Dual Complete® ONE (HMO D-SNP) if you are not eligible to remain a member on this basis. UnitedHealthcare Dual Complete® ONE (HMO D-SNP) must disenroll you if you do not meet this requirement.

Section 3 Important Membership Materials You Will Receive

Section 3.1 Your UnitedHealthcare plan 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 and for prescription drugs you get at network **pharmacies**.

Here's a sample UnitedHealthcare member ID card to show you what yours may 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 Dual Complete® ONE (HMO D-SNP) membership 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 plan 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 and Pharmacy Directory

The **Provider and Pharmacy Directory** lists our network providers and durable medical equipment suppliers. This directory also identifies which providers participate in Medicaid.

Network providers are the doctors and other health care professionals, medical groups, and durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full.

You must use network providers to get your medical care and 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 UnitedHealthcare Dual Complete® ONE (HMO D-SNP) authorizes use of out-of-network providers.

If you don't have your copy of the **Provider and Pharmacy Directory**, you can request a copy from Customer Service.

The pharmacy directory lists our network pharmacies

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the **Provider and Pharmacy Directory** to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have the **Provider and Pharmacy Directory**, you can get a copy from Customer Service. You can also find this information on our website at myuhc.com/CommunityPlan.

Section 3.3 The plan's List of Covered Drugs (Formulary)

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

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare and Medicaid. Medicare and Medicaid have approved the UnitedHealthcare Dual Complete® ONE (HMO D-SNP) Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (myuhc.com/CommunityPlan) or call Customer Service.

Section 4 Your monthly costs for UnitedHealthcare Dual Complete® ONE (HMO D-SNP)

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for UnitedHealthcare Dual Complete® ONE (HMO D-SNP).

Section 4.2 Monthly Medicare Part B Premium

As a member of this plan, Medicaid pays your Medicare Part B Premium for you.

Section 5 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, pharmacists, 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 and drugs are covered 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 health insurance coverage you have (such as from your employer, your spouse'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 6 How other insurance works with our plan

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 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 and/or employer group health plans have paid.

Chapter 2

Important phone numbers and resources

Section 1 UnitedHealthcare Dual Complete® ONE (HMO D-SNP) contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan’s Customer Service

For assistance with claims, billing, or UnitedHealthcare member ID card questions, please call or write to UnitedHealthcare Dual Complete® ONE (HMO D-SNP) Customer Service. We will be happy to help you.

| Method | Customer Service – Contact information |
|----------------|---|
| Call | 1-800-514-4911 Calls to this number are free. Available 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept. Customer Service also has free language interpreter services available for non-English speakers. |
| TTY | 711 Calls to this number are free. Available 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept. |
| Write | UnitedHealthcare Customer Service Department PO Box 30769 Salt Lake City, UT 84130-0769 |
| Website | myuhc.com/CommunityPlan |

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

| Method | Coverage Decisions for Medical Care – Contact information |
|----------------|---|
| Call | 1-800-514-4911 Calls to this number are free. Available 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept. |
| TTY | 711 Calls to this number are free. Available 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept. |
| Write | UnitedHealthcare Customer Service Department (Organization Determinations) PO Box 30769 Salt Lake City, UT 84130-0769 |
| Website | myuhc.com/CommunityPlan |

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 8 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**).

| Method | Appeals for Medical Care — Contact information |
|----------------|--|
| Call | 1-800-514-4911 Calls to this number are free. Available 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept. |
| TTY | 711 Calls to this number are free. Available 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept. |
| Fax | For fast/expedited appeals only: 1-844-226-0356 |
| Write | UnitedHealthcare Appeals and Grievances Department P.O. Box 6103 MS CA124-0187 Cypress, CA 90630-0023 |
| Website | myuhc.com/CommunityPlan |

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 or pharmacies, 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 8 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**).

| Method | Complaints about Medical Care – Contact information |
|-------------------------|---|
| Call | 1-800-514-4911 Calls to this number are free. Available 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept. |
| TTY | 711 Calls to this number are free. Available 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept. |
| Fax | For fast/expedited complaints only: 1-844-226-0356 |
| Write | UnitedHealthcare Appeals and Grievances Department P.O. Box 6103 MS CA124-0187 Cypress, CA 90630-0023 |
| Medicare website | You can submit a complaint about UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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 the cost for medical care or a drug 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 6 (**Asking us to pay a bill you have received for covered medical services or drugs**).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 8 (**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**) for more information.

| Method | Payment Requests – Contact information |
|----------------|---|
| Call | 1-800-514-4911 Calls to this number are free. Available 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept. |
| TTY | 711 Calls to this number are free. Available 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept. |
| Write | UnitedHealthcare PO Box 5250 Kingston, NY 12402-5250 |
| Website | myuhc.com/CommunityPlan |

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. |

| Method | Medicare — Contact information |
|---------|--|
| Website | <p data-bbox="404 383 601 416">medicare.gov</p> <p data-bbox="404 433 1488 612">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.</p> <p data-bbox="404 631 1391 698">The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul data-bbox="433 717 1480 950" style="list-style-type: none"><li data-bbox="433 717 1451 750">• Medicare Eligibility Tool: Provides Medicare eligibility status information.<li data-bbox="433 769 1480 950">• 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. <p data-bbox="404 970 1441 1037">You can also use the website to tell Medicare about any complaints you have about UnitedHealthcare Dual Complete® ONE (HMO D-SNP):</p> <ul data-bbox="433 1056 1480 1280" style="list-style-type: none"><li data-bbox="433 1056 1480 1280">• Tell Medicare about your complaint: You can submit a complaint about UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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. <p data-bbox="404 1300 1488 1515">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.)</p> |

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 New Jersey the SHIP is called the State Health Insurance Assistance Program (SHIP).

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 **medicare.gov**
- Click on “**Talk to Someone**” in the middle of the homepage
- You now have the following options
 - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
 - Option #2: You can select your STATE from the drop down menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

| Method | State Health Insurance Assistance Program (New Jersey SHIP)–Contact information |
|----------------|--|
| Call | 1-800-792-8820 |
| TTY | 711 |
| Write | NJ State Health Insurance Assistance Program PO Box 807 Trenton, NJ 08625 |
| Website | state.nj.us/humanservices/doas/services/ship/ |

Section 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For New Jersey, the Quality Improvement Organization is called Livanta Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) Program.

Livanta BFCC-QIO Program 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.

Livanta BFCC-QIO Program is an independent organization. It is not connected with our plan.

You should contact Livanta BFCC-QIO Program 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 | Livanta (New Jersey's Quality Improvement Organization (QIO))– Contact information |
|---------|--|
| Call | 1-866-815-5440 Available 8 a.m.–8 p.m. local time, Monday–Friday. 11 a.m.–3 p.m. local time, Saturday and Sunday. |
| TTY | 1-866-868-2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| Write | Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701-1105 |
| Website | livantaqio.com/en/states/new_jersey |

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 a.m.–7 p.m. local time, Monday–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 a.m.–7 p.m. local time, Monday–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.

Because you are eligible for and enrolled in both Medicare and Medicaid, your coverage through our plan includes coverage for all of the benefits you are entitled to under Medicaid managed care (also known as NJ FamilyCare). As a result, UnitedHealthcare Dual Complete ONE (HMO D-SNP) covers Medicaid benefits such as hearing aids, routine vision exams, and comprehensive dental services. Additionally, Medicaid pays your Part B premium for you.

If you have questions about the assistance you get from Medicaid, contact the NJ Department of Human Services, Division of Medical Assistance Health Services (Medicaid).

| Method | NJ Department of Human services, Division of Medical Assistance and Health Services–Contact information |
|----------------|---|
| Call | 1-800-701-0710 Available 8 a.m. - 5 p.m. local time, Monday - Friday. |
| TTY | 711 Calls to this number are free. Available 8 a.m. - 5 p.m. local time, Monday - Friday. |
| Write | NJ Department of Human Services Division of Medical Assistance and Health Services PO Box 712 Trenton, NJ 08625-0712 |
| Website | state.nj.us/humanservices/dmahs/ |

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

| Method | The NJ Department of Banking and Insurance, Office of the Insurance Ombudsman—Contact information |
|----------------|---|
| Call | 1-800-446-7467 Available 8 a.m.–5 p.m. local time, Monday–Friday. |
| TTY | 711 |
| Write | The Office of the Insurance Ombudsman NJ Department of Banking and Insurance PO Box 472 Trenton, NJ 08625-0472 |
| Website | state.nj.us/dobi/ombuds.htm |

The New Jersey Office of the State Long-Term Care Ombudsman program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

| Method | New Jersey Long-Term Care Ombudsman—Contact information |
|----------------|--|
| Call | 1-877-582-6995 Available 8:45 a.m.–5 p.m. local time, Monday–Friday. |
| TTY | 711 |
| Write | NJ Long-Term Care Ombudsman PO Box 852 Trenton, NJ 08625-0852 |
| Website | nj.gov/ooie/ |

Section 7 Information about programs to help people pay for their prescription drugs

The **medicare.gov** website (**[medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/6-ways-to-get-help-with-prescription-costs](https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/6-ways-to-get-help-with-prescription-costs)**) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare’s “Extra Help” Program

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this “Extra Help.”

If you have questions about “Extra Help,” call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048** (applications), 24 hours a day, 7 days a week;
- The Social Security Office at **1-800-772-1213**, between 7 am to 7 pm, Monday through Friday. TTY users should call **1-800-325-0778**; or
- Your State Medicaid Office (applications) (See Section 6 of this chapter for contact information).

Section 8 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 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. to 12:00 p.m. 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 9 **Do you have “group insurance” or other health insurance from an employer?**

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

Chapter 3

Using the plan for your medical and other covered services

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

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

For the details on what medical care and other services are covered by our plan, use the Medical Benefits Chart in the next chapter, Chapter 4 (**Medical Benefits Chart, what is covered**).

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 and other covered 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 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 nothing for covered services.
- **“Covered services”** include all the medical care, health care services, supplies, equipment, and Prescriptions Drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

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

UnitedHealthcare Dual Complete® ONE (HMO D-SNP) will generally cover your medical care and other services 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 that you will have to pay the provider in full for the services furnished. **Here are four 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 or Medicaid 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. In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
 - 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.
 - Family Planning services may be obtained via out-of-network providers. In these cases, the services will be covered directly via Medicaid fee-for-service.

Section 2 Use providers in the plan's network to get your medical care and other services

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your 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 and Pharmacy Directory** at the time of your enrollment. You may, however, visit any network provider you choose. We strongly recommend that you select a PCP from the **Provider and Pharmacy Directory** at the time of enrollment.

For a copy of the most recent **Provider and Pharmacy Directory**, or for help in selecting a PCP, call Customer Service or visit uhcommunityplan.com/nj.html 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 in our plan.

If you want to change your PCP, call Customer Service. 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.

Under certain circumstances, you may continue receiving covered services from a participating physician or other health care professional who has left the network for up to four months beyond the effective date of termination (the end of the notice period).

Additionally, if you are undergoing certain courses of treatment, you may receive longer periods of care as indicated below:

- Pregnancy — up to the postpartum evaluation (up to six weeks after delivery).
- Post-operative follow-up care (up to six months).
- Oncological treatment (up to one year).
- Psychiatric treatment (up to one year).

Section 2.2 What kinds of medical care and other services can you get without a referral from your PCP?

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations
- Emergency services from network providers or from out-of-network providers
- Urgently needed services are 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.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)

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

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

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. You are not responsible for getting any prior authorizations needed for medical and other covered services under your Plan.

Please refer to the **Provider and Pharmacy Directory** for a listing of plan specialists available through your network, or you may consult the **Provider and Pharmacy Directory** online at uhcommunityplan.com/nj.html.

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

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 leaves 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 make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service.
- 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 8.

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 the Medical Benefits Chart in Chapter 4, Section 2.1.

Section 2.4 How to get care from out-of-network providers

Care that you receive from out-of-network providers will not be covered unless the care meets one of the four exceptions described in Section 1.2 of this chapter. As a reminder, we will arrange for coverage of medically necessary covered services through out-of-network providers if they are not reasonably available through our network. You may receive Family Planning services through out-of-network providers and those services will be covered directly through Medicaid fee-for-service. 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. Please call your Care Manager or Customer Service for help with how to get care from out-of-network providers.

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 United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.

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.

If you receive emergency or urgently-needed services outside of the United States or its territories, you generally will be required to pay the bill at the time you receive the services. Most foreign providers are not eligible to receive reimbursement directly from Medicare, and will ask you to pay for the services directly. Ask for a written, detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt to us to pay you back. You should be prepared to assist us in obtaining any additional information necessary to properly process your request for reimbursement, including medical records.

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.

In most situations, if you are in the plan's service area, we will cover urgently needed care **only** if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider. Check your **Provider and Pharmacy Directory** for a list of network Urgent Care Centers or call Customer Service at **1-800-514-4911**, TTY **711**, 8am–8pm: 7 Days Oct-Mar; M–F Apr–Sept. for more information.

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 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: myuhc.com/CommunityPlan 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. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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

Section 4.1 You can ask us to pay for covered services

If you have paid for your covered services, or if you have received a bill for covered medical services, go to Chapter 6 (**Asking us to pay a bill you have received for covered medical services or drugs**) for information about what to do.

Section 4.2 What should you do if services are not covered by our plan?

UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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.

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. 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. 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.

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

If you participate in a study that Medicare or our plan 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 rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.

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-ResearchStudies.pdf](https://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-ResearchStudies.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.

Medicare Inpatient Hospital coverage limits apply. 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?

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 UnitedHealthcare Dual Complete ONE (HMO D-SNP) however, you will not acquire ownership of rented DME items, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan.

What happens to payments you have made for durable medical equipment (DME) 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 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, UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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 UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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. 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. If you join or leave our plan, the five-year cycle starts over.

Chapter 4

Medical Benefits Chart (what is covered)

Section 1 Understanding covered services

This chapter provides a Medical Benefits Chart that lists your covered services as a member of UnitedHealthcare Dual Complete® ONE (HMO D-SNP). 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 You pay nothing for your covered services

Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (See Chapter 3 for more information about the plans' rules for getting your care).

Section 2 Use the Medical Benefits Chart to find out what is covered

Section 2.1 Your medical, long-term care, and home and community-based care benefits as a member of the plan

The Medical Benefits Chart on the following pages lists the services UnitedHealthcare Dual Complete® ONE (HMO D-SNP) covers. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.
- 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 us. Covered services that need approval in advance are marked *in italics* in the Medical Benefits Chart.

Other important things to know about our coverage:

- You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost-sharing for Medicare services including coinsurance, copayments, and deductibles. Medicaid also covers services Medicare does not cover, like long-term care, home and community-based services, over-the-counter drugs, comprehensive dental services, hearing aids, and vision.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your **Medicare & You 2023** 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.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.
- Our plan covers all of your Medicare and Medicaid benefits at no cost to you. We have a single, integrated benefit package that includes your Medicare benefits (including Part D prescription drugs) and your Medicaid benefits along with extra supplemental benefits that ordinary Medicare and Medicaid don't cover. The Medical Benefits Chart in this section lists all of these benefits for you in one place.
- If you are within our plan's six-month period of deemed continued eligibility, we will continue to provide all appropriate Medicare Advantage plan covered benefits. However, during this period, Medicaid-only benefits may not be covered by our plan. To find out if a benefit is Medicaid-only, and/or to find out if it will be covered, you can call Customer Service at the number on the back cover of this document. All of your Medicare services, including Medicare Part D prescription drugs, will continue to be covered at \$0 cost-sharing (no copayments, coinsurance, or deductibles) during the period of deemed continued eligibility.

You do not pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.

Important Benefit Information for all Enrollees Participating in Wellness and Health Care Planning (WHP) Services

Because UnitedHealthcare Dual Complete® ONE (HMO D-SNP) participates in D-SNP Healthy Food, you will be eligible for the following WHP services, including advance care planning (ACP) services:

- What are ACP services?
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.
- You may get advance care planning assistance by contacting Customer Service (phone numbers are printed on the back cover of this booklet).
- Please go to the Healthy Foods Benefit row in the Medical Benefits Chart in Chapter 4 for further detail.

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

Medical Benefit Chart

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p> Abdominal Aortic Aneurysm Screening</p> <p>A one-time 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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p>Acupuncture for chronic low back pain</p> <p>For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. <p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.</p> <p>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:</p> <ul style="list-style-type: none"> • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|---|--|
| <p>Acupuncture for chronic low back pain (continued)</p> <ul style="list-style-type: none"> • 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. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p> | |
| <p>Ambulance Services</p> <p>Covered ambulance services 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.</p> <p>Non-emergency transportation by ambulance is appropriate if it is 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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for non-emergency transportation.</i></p> |
| <p>Annual Routine Physical Exam</p> <p>Annual Routine Physical Exam Includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn’t include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Annual Routine Physical Exam visits do not need to be scheduled 12 months apart but are limited to one each calendar year.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p> Annual Wellness Visit</p> <p>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.</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p>Autism Spectrum Disorder Services</p> <p>For all members with an Autism Spectrum Disorder (ASD) diagnosis, the plan shall provide Applied Behavioral Analysis (ABA), augmentative and alternative communication services and devices, Sensory Integration (SI) services, allied health services (physical therapy, occupational therapy and speech therapy), and Developmental Relationship based services including but not limited to DIR, DIR Floortime and the Greenspan approach therapy.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p> Bone Mass Measurement</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p> Breast Cancer Screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p>Cardiac Rehabilitation Services</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |
| <p> Cardiovascular Disease Risk Reduction Visit (Therapy For Cardiovascular Disease)</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p> Cardiovascular Disease Testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) are covered annually for all members 20 years of age or older, and more frequently if medically necessary.</p> | <p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing.</p> |
| <p> Cervical And Vaginal Cancer Screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once 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 | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p>Chiropractic Services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position). • Clinical laboratory services; certain medical supplies; durable medical equipment; prefabricated orthoses; physical therapy services; and diagnostic radiological services when they are prescribed by a chiropractor within their scope of practice. | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |
| <p> Colorectal Cancer Screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months <p>One of the following every 12 months:</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy | <p>There is no coinsurance, copayment, or deductible</p> |

| Services that are covered for you | What you must pay when you get these services |
|---|--|
| <p>Dental Services</p> <p>Coverage includes diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services.</p> <p>Some procedures may require prior authorization with documentation of medical necessity. Orthodontic services are allowed for children and are age restricted and only approved with adequate documentation of a handicapping malocclusion or medical necessity.</p> <p>Examples of covered services include (but are not limited to): oral evaluations (examinations); X-rays and other diagnostic imaging; dental cleaning (prophylaxis); topical fluoride treatments; fillings; crowns; root canal therapy; scaling and root planing; complete and partial dentures; oral surgical procedures (to include extractions); intravenous anesthesia/sedation (where medically necessary for oral surgical procedures).</p> <p>Dental examinations, cleanings, fluoride treatment and any necessary X-rays are covered twice per rolling year.</p> <p>Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs.</p> <p>Dental treatment in an operating room or ambulatory surgical center is covered with prior authorization and documentation of medical necessity.</p> | <p>There is no coinsurance, copayment or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |
| <p> Depression Screening</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|--|---|
| <p> Diabetes Screening</p> <p>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.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|--|--|
| <p> Diabetes Self-Management Training, Diabetic Services and Supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • 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. <p>We only cover the brands of blood glucose monitors and test strips specified within the list to the right.</p> <p>UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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 UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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 UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p>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.</p> <p>Other brands are not covered by this plan.</p> <p>There are no brand limitations for Continuous Glucose Monitors.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p> Diabetes Self-Management Training, Diabetic Services and Supplies (continued)</p> <p>If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 8, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).</p> <ul style="list-style-type: none"> • 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. • Diabetes self-management training is covered under certain conditions. | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |
| <p>Diabetes Testing and Monitoring</p> <p>Covers yearly eye exams for diabetic retinopathy, and foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations. Covered beyond Medicare Part B limits.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |
| <p>Doula Services</p> <p>The services of a doula are covered. A doula is a trained professional who provides continuous physical, emotional, and informational support to the birthing parent throughout the perinatal period. A doula can also provide informational support for community-based resources. A doula does not replace a licensed medical professional, and cannot perform clinical tasks. Prior to the initiation of visits, doula care must be recommended by a licensed practitioner.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|--|---|
| <p>Durable Medical Equipment (DME) and Related Supplies (For a definition of “durable medical equipment,” see Chapter 11 as well as Chapter 3, Section 7 of this document.)</p> <p>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, oxygen equipment, nebulizers, and walkers.</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider must obtain prior authorization.</i></p> |
| <p>Emergency Care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>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.</p> <p>Worldwide coverage for 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 and/or elective procedures are not covered.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p>Please see Chapter 6, Section 1.1 for expense reimbursement for worldwide services.</p> <p>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 network hospital in order for your care to continue to be covered.</p> |

| Services that are covered for you | What you must pay when you get these services |
|--|---|
| <p>Early and Periodic Screening, Diagnostic and Treatment (EPSDT)</p> <p>For enrollees under 21 years of age, the following are covered: well child care, preventive screenings, medical examinations, vision and hearing screenings and services, immunizations, lead screening, and private duty nursing services. Private duty nursing is covered for eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p>Family Planning Services and Supplies</p> <p>Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling.</p> <p>Services furnished by out-of-network providers are covered directly by Medicaid Fee-for-Service.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p>Federally Qualified Health Centers (FQHC)</p> <p>Includes outpatient and primary care services from community-based organizations. Covered for services rendered beyond Medicare Part B limits.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|--|--|
| <p>Food, Over-The-Counter (OTC) and Utility Bill Credit</p> <p>With this benefit, you'll get a credit loaded to your UnitedHealthcare UCard™ each month to pay for covered groceries, OTC items and certain utility bills. Unused credits expire at the end of each month.</p> <p>Covered items include:</p> <ul style="list-style-type: none"> • Healthy foods like fruits, vegetables, meat, seafood, dairy products, water and more. • Brand name and generic OTC products, like vitamins, pain relievers, toothpaste, cough drops and more. • Eligible utility bills like electricity, gas, water and internet. The service address must match an address we have on file for you. <p>The credit cannot be used to buy tobacco or alcohol.</p> <p>You can use your credit at thousands of participating stores or place an order online or over the phone through your catalog. Get free home delivery when you spend \$35 or more. To receive a paper catalog, call Customer Service or the number on the Vendor Information Sheet. You can also use your credit to pay eligible utility bills online, over the phone or at your local Walmart MoneyCenter or Customer Service Desk.</p> <p>Visit the UCard Hub at myuhc.com/CommunityPlan to find participating stores, check your balance, place an order online or pay utility bills.</p> <p>You can get more information by viewing the Vendor Information Sheet at uhcommunityplan.com/nj, or by calling Customer Service to have a paper copy sent to you.</p> | <p>Provided by: Solutran</p> <p>Monthly credit is \$300.</p> |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p>Hearing Services</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p>We cover routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration.</p> <p>Hearing aids, as well as associated accessories and supplies, are covered.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |
| <p> HIV Screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p>Home Health Agency Care</p> <p>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.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider must obtain prior authorization.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
|--|---|
| <p>Home infusion therapy</p> <p>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).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p>Home Support Services</p> <p>With this benefit, you get a quarterly credit to spend on extra support at home. Credits are added to your account every quarter and expire at the end of the year.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Companionship • Meal prep • Pest control • Home repair • Home modification • Errands • Respite • Intermittent yard maintenance • Snow removal <p>To access this benefit, call Customer Service at 1-800-514-4911 (TTY 711), or visit myuhc.com/CommunityPlan.</p> | <p>Quarterly credit for extra support at home is \$150.</p> <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Hospice Care</p> <p>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.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>We also cover certain durable medical equipment, as well as spiritual and grief counseling. For members under 21 years of age, both palliative and curative care are covered.</p> <p>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 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.</p> <p>For services that are covered by UnitedHealthcare Dual Complete® ONE (HMO D-SNP) but are not covered by Medicare Part A or B: UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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.</p> <p>For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (What if you're in Medicare-certified hospice).</p> | <p>When you enroll in a Medicare-certified hospice program, hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not UnitedHealthcare Dual Complete® ONE (HMO D-SNP).</p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Hospice Care (continued)</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. All of your medical care not related to your terminal prognosis is covered as it normally would be.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p> | |
| <p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We also cover some vaccines under our Part D prescription drug benefit.</p> <p>The full childhood immunization schedule is covered for members under the age of 21.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Inpatient Hospital Care</p> <p>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.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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 • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical therapy, speech language therapy, and occupational therapy • Inpatient substance abuse disorder treatment services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow (including autologous 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 and Pharmacy 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 UnitedHealthcare Customer Service at 1-800-514-4911 (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. | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider must obtain prior authorization.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Inpatient Hospital Care (continued)</p> <p>If UnitedHealthcare Dual Complete ONE (HMO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose 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, 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.</p> <ul style="list-style-type: none"> • Blood—including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint of blood that you need. • Physician services <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare—Ask!” 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.</p> | |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Inpatient services in a psychiatric hospital</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Mental health care services that require a hospital stay. The plan covers inpatient services in a psychiatric hospital (services beyond 190 days are covered). • All members are covered by the plan for acute inpatient hospitalization in a general hospital, regardless of the admitting diagnosis or treatment. Mental health services are covered by the plan for all members (services beyond 190 days are covered). • Services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), or critical access hospital are covered. • Inpatient Medical Detox (Medically Managed Inpatient Withdrawal Management in a hospital setting) is covered. | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization.</i></p> |
| <p>Mammograms</p> <p>Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p>Managed Long Term Services and Supports (MLTSS)</p> <p>The MLTSS program provides Home- and Community-Based services for members that require the level of care typically provided in a Nursing Facility, and allows them to receive necessary care in a residential or community setting. MLTSS services include (but are not limited to): assisted living services; cognitive, speech, occupational, and physical therapy; chore services; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); vehicle modifications; social adult day care; and non-medical transportation. MLTSS is available to members who meet certain clinical and financial requirements.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Meal Benefit</p> <p>This benefit can be used immediately following an inpatient hospital or skilled nursing facility (SNF) stay if recommended by a provider.</p> <p>Benefit guidelines:</p> <ul style="list-style-type: none"> • Receive up to 28 home-delivered meals for up to 14 days • First meal delivery may take up to 72 hours after ordered • Some restrictions and limitations may apply <p>You can view the Vendor Information Sheet at uhcommunityplan.com/nj.html, or call Customer Service to have a paper copy sent to you.</p> | <p>Provided by: Mom’s Meals</p> <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider must obtain prior authorization.</i></p> |
| <p>Medical Day Care</p> <p>Covers preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p> Medical Nutrition Therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 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 2 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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Medicare Part B prescription drugs</p> <p>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:</p> <ul style="list-style-type: none"> • 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 • 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 • 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 • Chemotherapy Drugs, and the Administration of chemotherapy drugs <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy:</p> <p>medicare.uhc.com/medicare/member/documents/part-b-step-therapy.html</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services/drugs.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Medicare Part B prescription drugs (continued)</p> <p>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. If you are prescribed a new 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 this drug. (For more information, see Chapter 8, What to do if you have a problem or complaint (coverage decisions, appeals, complaints)). Please contact Customer Service for more information.</p> <p>We also cover some vaccines under our Part B and Part D prescription drug benefit.</p> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered.</p> | |
| <p>NurseLine</p> <p>NurseLine services available, 24 hours a day, 7 days a week. Speak to a registered nurse (RN) about your medical concerns and questions.</p> <p>You can view the Vendor Information Sheet at uhcommunityplan.com/nj.html, or call Customer Service to have a paper copy sent to you.</p> | <p>Provided by: NurseLine</p> <p>There is no coinsurance, copayment, or deductible.</p> |
| <p>Nurse Midwife Services</p> <p>Nurse Midwife services are covered.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p> Obesity Screening and Therapy to Promote Sustained Weight Loss</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Opioid treatment program services</p> <p>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:</p> <ul style="list-style-type: none">• 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 disorder counseling• Individual and group therapy• Toxicology testing• Intake activities• Periodic assessments | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider must obtain prior authorization.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Outpatient Diagnostic Tests and Therapeutic Services and Supplies</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies. • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood—including storage and administration (this includes processing and handling of blood). Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint of blood that you need. • Other outpatient diagnostic tests—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. • Other outpatient diagnostic tests—Radiological diagnostic services, including X-rays, performed in a physician’s office or at a freestanding facility (such as a radiology center or medical clinic). • 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). | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Outpatient Hospital Observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>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.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. 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.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare–Ask!” or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p> <p>You can call these numbers for free, 24 hours a day, 7 days a week.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Outpatient Hospital Services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself • Outpatient infusion therapy. <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. 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.</p> <p>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 https://www.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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Outpatient Mental Health Care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. Services provided by an Independent Practitioner Network or IPN (Psychiatrist, Psychologist or APN) are also covered.</p> <p>Outpatient psychiatric services are covered for members of all ages in Private Psychiatric Hospitals and General Hospital Outpatient settings.</p> <p>Additionally, the plan covers the following services:</p> <ul style="list-style-type: none"> • Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments) • Mental Health Outpatient (Clinic/Hospital Services) • Partial Care and Medication Management | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |
| <p>Outpatient Rehabilitation Services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>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).</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Outpatient Substance Use Disorder Treatment Services</p> <p>The plan covers substance use disorder screening, referrals, prescription drugs, and treatment of conditions. Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Non-Medical Detoxification/Non-Hospital based withdrawal management • Substance Use Disorder Short Term Residential • Ambulatory withdrawal Management with extended on-site monitoring/Ambulatory Detoxification • Substance Use Disorder Partial Care • Substance Use Disorder Intensive Outpatient • Substance Use Disorder Outpatient • Opioid Treatment Services (Methadone Medication Assisted Treatment) • Opioid Treatment Services (Non-Methadone Medication Assisted Treatment) • Peer Recovery Support Services (PRSS) | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |
| <p>Outpatient Surgery, and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers</p> <p>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. 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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |
| <p>Pap Smears and Pelvic Exams</p> <p>Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. All associated laboratory costs are covered. Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Partial Hospitalization Services</p> <p>“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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |
| <p>Personal Care Assistance</p> <p>Covers health related tasks performed by a qualified individual in a beneficiary’s home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary’s written plan of care.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p>Personal Emergency Response System (PERS)</p> <p>With the Personal Medical Emergency Response System help is only a button away. The Personal Emergency Response System can give you peace of mind knowing that in any emergency situation you can get help quickly, even if you can’t get to the phone. We will install the system in your home and cover the monthly monitoring charges.</p> <p>Prior authorization is not required. Contact Customer Service for benefit details.</p> <p>You can view the Vendor Information Sheet at uhcommunityplan.com/nj.html, or call Customer Service to have a paper copy sent to you.</p> | <p>Provided by: Tunstall Americas</p> <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Physician/Practitioner Services, including Doctor’s Office Visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical care or surgery services furnished in a physician’s office. • Medically-necessary medical or surgical services furnished in a certified ambulatory surgical center or hospital outpatient department or any other location. • Consultation, diagnosis, and treatment by a specialist • Services provided by other health care professionals • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Second opinion by another network provider prior to surgery • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member’s home • Telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for Specialist services.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Physician/Practitioner Services, including Doctor’s Office Visits (continued)</p> <ul style="list-style-type: none"> • Virtual visits and consultations that can be conducted via telehealth with PCPs, specialists, and other providers are covered as if it was an in-person visit. • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Monitoring services in a physician’s office or outpatient hospital setting if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as ‘Coumadin Clinic’ services) • Medically-necessary medical or surgical services that are covered benefits and are furnished by a physician in your home or a nursing home in which you reside • Additional telehealth services, including: <ul style="list-style-type: none"> – Covered services included in Virtual Medical Visits <ul style="list-style-type: none"> • Primary Care Provider • Urgently Needed Services • Cardiac Rehabilitation Services • Intensive Cardiac Rehabilitation Services • Specialist • Other Health Care Professionals • Outpatient Rehabilitation Services—Occupational Therapy • Outpatient Rehabilitation Services—Physical Therapy and Speech-Language Therapy | |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Physician/Practitioner Services, including Doctor’s Office Visits (continued)</p> <ul style="list-style-type: none"> • Telehealth or virtual medical visits are medical visits delivered to you outside of medical facilities by network providers that have appropriate online technology and live audio/video capabilities to conduct the visit. <ul style="list-style-type: none"> – 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. – Virtual Mental Health Visits are mental health visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/video capabilities. Visit virtualvisitsmentalhealth.uhc.com to learn more and schedule a virtual appointment. • Covered services include individual mental health services. • Not all conditions can be treated through virtual visits. The virtual visit provider will identify if you need to see an in-person provider for treatment. • You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the services via telehealth. | |
| <p>Podiatry Services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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. • Therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts. • Routine exams. | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
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| <p>Private Duty Nursing</p> <p>Covered for eligible beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. It is covered for MLTSS members of any age.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p> Prostate Cancer Screening Exams</p> <p>For men age 50 and older (and for men 40 and older with a family history of prostate cancer or other risk factors), covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p>Prosthetic Devices and Related Supplies</p> <p>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 Care” later in this section for more detail.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |
| <p>Pulmonary Rehabilitation Services</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p> Screening and Counseling to Reduce Alcohol Misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>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 qualified primary care doctor or practitioner in a primary care setting.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>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 or 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.</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|--|---|
| <p> Screening For Sexually Transmitted Infections (STIs) and Counseling to Prevent STIs</p> <p>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.</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p>Services To Treat Kidney Disease</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and 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) <p>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.”</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p>Skilled Nursing Facility (SNF) Care (For a definition of “skilled nursing facility care,” see Chapter 11 of this document. Skilled nursing facilities are sometimes called “SNFs.”) Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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 of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn’t a network provider, if the facility accepts our plan’s amounts for payment</p> <ul style="list-style-type: none"> • 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). | <p>There is no coinsurance, copayment, or deductible. No prior hospital stay is required. <i>Your provider must obtain prior authorization.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p>Skilled Nursing Facility (SNF) Care (continued)</p> <ul style="list-style-type: none"> • A SNF where your spouse is living at the time you leave the hospital. • Long Term (custodial) care in a Nursing Facility is covered for those who meet Nursing Facility level of care criteria. | |
| <p> Smoking and Tobacco Use Cessation (Counseling to Stop Smoking or Tobacco Use)</p> <p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p> <p>The plan also covers over-the-counter (OTC) smoking cessation products, including nicotine gums, nicotine lozenges and nicotine patches.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • 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 <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

| Services that are covered for you | What you must pay when you get these services |
|---|--|
| <p>Transportation</p> <p>Non-emergency transportation, such as mobile assistance vehicles (MAVs), non-emergency basic life support (BLS) ambulance (stretcher), and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage), are covered directly by Medicaid Fee-for Service (FFS). All non-emergency transportation is arranged through the state’s transportation vendor, Modivcare. To schedule transportation, call Modivcare at 1-866-527-9933. You can ask your PCP or Care Manager to help you to arrange this service. Please call Customer Service for more information.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |
| <p>Urgently Needed Services</p> <p>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. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. 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. Covered services include urgently needed services obtained at a retail walk-in clinic or an urgent care center.</p> <p>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 and/or elective procedures are not covered.</p> | <p>There is no coinsurance, copayment, or deductible.</p> <p>Please see Chapter 6, Section 1.1 for expense reimbursement for worldwide services.</p> |

| Services that are covered for you | What you must pay when you get these services |
|---|---|
| <p> Vision Care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including a comprehensive eye exam once per year and treatment for age-related macular degeneration. • 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. For all others age 35 or older, a glaucoma screening is covered every five years. • 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. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any updates are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating). • Optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses, are covered. • Replacement lenses and frames (or contact lenses) are covered once every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older. | <p>There is no coinsurance, copayment, or deductible.</p> <p><i>Your provider may need to obtain prior authorization for some services.</i></p> |

| Services that are covered for you | What you must pay when you get these services |
|--|---|
| <p> “Welcome to Medicare” preventive visit</p> <p>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.</p> <p>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.</p> | <p>There is no coinsurance, copayment, or deductible.</p> |

Section 3 What services are not covered by the plan?

Section 3.1 Services not covered by the plan (exclusions)

This section tells you what services are “excluded.”

The chart below describes some services and items that aren’t covered by the plan under any conditions or are covered by the plan 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 8, Section 6.3 in this document.)

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.

| Services not covered by Medicare or Medicaid | Not covered under any condition | Covered only under specific conditions |
|---|---------------------------------|--|
| Acupuncture | | <p style="text-align: center;">✓</p> <p>Covered.</p> |
| Cosmetic surgery or procedures | | <p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • 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. |
| <p>Custodial care. (Care that helps with activities of daily living that does not require professional skills or training, e.g. bathing and dressing.)</p> <p>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.</p> | | <p style="text-align: center;">✓</p> <p>Covered for all members who meet Nursing Facility level of care criteria.</p> |

| Services not covered by Medicare or Medicaid | Not covered under any condition | Covered only under specific conditions |
|--|---------------------------------|--|
| <p>Experimental medical and surgical procedures, equipment and medications.</p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.</p> | | <p style="text-align: center;">✓</p> <p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.</p> <p>(See Chapter 3, Section 5 for more information on clinical research studies.)</p> |
| <p>Fees charged for care by your immediate relatives or members of your household.</p> | <p>✓</p> | |
| <p>Full-time nursing care in your home.</p> | | <p style="text-align: center;">✓</p> <p>Private Duty Nursing is covered for members with EPSDT or MLTSS.</p> |
| <p>Home-delivered meals</p> | | <p style="text-align: center;">✓</p> <p>Home-delivered meals are covered for members with MLTSS.</p> |
| <p>Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.</p> | | <p style="text-align: center;">✓</p> <p>Chore services are covered for members with MLTSS.</p> |
| <p>Immunizations for foreign travel purposes.</p> | <p>✓</p> | |
| <p>Naturopath services (uses natural or alternative treatments).</p> | <p>✓</p> | |
| <p>Non-routine dental care</p> | | <p style="text-align: center;">✓</p> <p>Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</p> |

| Services not covered by Medicare or Medicaid | Not covered under any condition | Covered only under specific conditions |
|---|---------------------------------|--|
| Orthopedic shoes or supportive devices for the feet | | <p style="text-align: center;">✓</p> <p>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.</p> |
| Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television. | ✓ | |
| Private room in a hospital. | | <p style="text-align: center;">✓</p> <p>Covered only when medically necessary.</p> |
| Reversal of sterilization procedures and or non-prescription contraceptive supplies. | ✓ | |
| Routine chiropractic care | | <p style="text-align: center;">✓</p> <p>Manual manipulation of the spine to correct a subluxation is covered.</p> <p>The plan's coverage includes services such as clinical laboratory services; certain medical supplies; durable medical equipment; prefabricated orthoses; physical therapy services; and diagnostic radiological services when they are prescribed by a chiropractor within their scope of practice.</p> |

| Services not covered by Medicare or Medicaid | Not covered under any condition | Covered only under specific conditions |
|--|---------------------------------|--|
| Routine dental care, such as cleanings, fillings or dentures | | <p style="text-align: center;">✓</p> <p>The plan provides comprehensive coverage for dental services, including routine dental care, such as cleanings, fillings and dentures.</p> |
| Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids. | | <p style="text-align: center;">✓</p> <p>Eye exam and one pair of standard eyeglasses (or standard contact lenses) are covered for people after cataract surgery.</p> <p>Other services and screenings are covered as well.</p> |
| Routine foot care | | <p style="text-align: center;">✓</p> <p>Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.</p> <p>The plan also covers routine exams.</p> |
| Routine hearing exams, hearing aids, or exams to fit hearing aids | | <p style="text-align: center;">✓</p> <p>The plan provides coverage for routine hearing exams, hearing aids, and exams to fit hearing aids.</p> |
| Services considered not reasonable and necessary, according to Original Medicare standards | <p>✓</p> | |

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.

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

Chapter 5

Using the plan's coverage for
Part D prescription drugs



How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the “Extra Help” program, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you.**

Section 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs.** Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

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

Section 1.1 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist or other prescriber) write your prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, **Fill your prescriptions at a network pharmacy or through the plan's mail-order service**).
- Your drug must be on the plan's **List of Covered Drugs (Formulary)** (we call it the “Drug List” for short). (See Section 3, **Your drugs need to be on the plan's “Drug List”**).
- Your drug must be used for a medically accepted indication. A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your **Provider and Pharmacy Directory**, visit our website (myuhc.com/CommunityPlan) or call Customer Service.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service or use the **Provider and Pharmacy Directory**. You can also find information on our website at myuhc.com/CommunityPlan.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your **Provider and Pharmacy Directory** or call Customer Service.

Section 2.3 Using the plan's mail-order service

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

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

Usually a mail-order pharmacy order will get to you in no more than ten business days. However, sometimes your mail-order may be delayed. If your mail-order is delayed, please follow these steps:

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

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

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

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

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by phone or mail.

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

Refills on mail-order prescriptions.

You also have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto refill program, please contact your pharmacy ten days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact the mail order pharmacy 10 days before your order will ship or you can let the pharmacy know when they notify you of an upcoming shipment.

Section 2.4 How can you get a long-term supply of drugs?

The plan offers two ways to get a long term supply (also called an “extended supply”) of “maintenance” drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long term medical condition.)

- **Some retail pharmacies** in our network allow you to get a long term supply of maintenance drugs. Your **Provider and Pharmacy Directory** tells you which pharmacies in our network can give you a long term supply of maintenance drugs. You can also call Customer Service for more information.
- You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy **only** when you are not able to use a network pharmacy. **Please check first with Customer Service** to see if there is a network pharmacy nearby.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

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

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you (Chapter 6, Section 2.1 explains how to ask the plan to pay you back.)

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

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

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

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

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

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

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- — **or** — Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The Drug List includes brand name and generic drugs

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

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, generics work just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Customer Service.

What is not on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 8.

Section 3.2 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we provide includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Service to find out if we cover it.)
2. Visit the plan's website (myuhc.com/CommunityPlan). The Drug List on the website is always the most current.

3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

Section 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

Please note that sometimes a drug may appear more than once in our drug list. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 8)

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version instead of the brand name drug.** However, if your provider has told us the medical reason that the generic drug will not work for you **OR** has written "No substitutions" on your prescription for a brand name drug **OR** has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called “**step therapy.**”

Quantity limits

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

Section 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered.
- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are options:

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

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

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

- **If you are a new member**, we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- **If you were in the plan last year**, we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- **This temporary supply will be for a maximum of 30 days.** If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**
We will cover one 31 day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For those current members with level of care changes:**
There may be unplanned transitions such as hospital discharges or level of care changes that occur after the first 90 days that you are enrolled as a member in our plan. If you are prescribed a drug that is not on our formulary or your ability to get your drugs is limited, you are required to use the plan's exception process. You may request a one time temporary supply of a maximum of 30 days to allow you time to discuss alternative treatment with your doctor or to pursue a formulary exception.

For questions about a temporary supply, call Customer Service.

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

1. You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2. You can ask for an exception

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

If you and your provider want to ask for an exception, Chapter 8, Section 7.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

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

- **Add or remove drugs from the Drug List.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic drug.**

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

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We also update our online Drug List on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand name drug on the Drug List (or we add new restrictions to the brand name drug)**
 - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear with the same or fewer restrictions. We may decide to keep the brand name drug on our Drug List, but immediately add new restrictions when the new generic is added.
 - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
 - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 8.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
 - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you right away.
 - Your prescriber will also know about this change, and can work with you to find another drug for your condition.

- **Other changes to drugs on the Drug List**

- We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the Drug List or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
- For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
- After you receive notice of this change, you should be working with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 8.

Changes to the Drug List that do not affect you during this plan year

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

In general, changes that will not affect you during the current plan year are:

- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use until January 1 of the next year. Until that date, you probably won't see any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

Section 7 What types of drugs are not covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means neither Medicare nor Medicaid pays for these drugs.

If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 8.) If the drug is excluded, you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.

- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration.
- Coverage for “off-label use” is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs listed below are not covered by Medicare or Medicaid.

- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Section 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, show your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for your drug.

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you.** See Chapter 6, Section 2.1 for information about how to ask the plan for reimbursement.)

Section 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or

skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

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

Check your **Provider and Pharmacy Directory** to find out if your LTC facility's pharmacy is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

Section 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

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

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

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

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

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 8 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, or you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs.

Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

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

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Customer Service.

Section 11 We send you reports that explain payments for your drugs

Section 11.1 We send you a monthly summary called the Part D Explanation of Benefits (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. In particular, there are two types of costs we keep track of:

We keep track of how much you have paid. This is called your **"out-of-pocket"** cost.

We keep track of your **"total drug costs."** This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written summary called the Part D **Explanation of Benefits** (it is sometimes called the "Part D EOB") when you have had one or more prescriptions filled through the plan during the previous month. The Part D EOB provides more information about the drugs you take. The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and any percentage change from first fill for each prescription claim of the same quantity.

Section 11.2 Help us keep our information about your drug payments up to date

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay for the drug. For instructions on how to do this, go to Chapter 6, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

If you are billed for a covered drug, you can ask our plan to pay the cost. For instructions on how to do this, go to Chapter 6, Section 2.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs.
- **Check the written report we send you.** When you receive the Part D **Explanation of Benefits** (a Part D EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

Chapter 6

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

Section 1 Situations in which you should ask us to pay for your covered services or drugs

Our network providers bill the plan directly for your covered services and drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, 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 you have already paid for a Medicaid service or item covered by the plan, 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 for medical services or drugs 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. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. 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. 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

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, ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, ask us to pay you back. 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 for the service, we will pay you back.

You can also receive emergency services from a provider outside the United States. If you receive emergency services outside of the United States, the provider may require that you pay for the cost of the services in full. Ask for a written, detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt to us to pay you back. You should be prepared to assist us in obtaining all of the information necessary to properly process your request for reimbursement, including medical records.

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

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- Whenever you get a bill from a network provider, 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, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

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 or drugs after your enrollment date, you can ask us to pay you back. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

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

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

Save your receipt and send a copy to us when you ask us to pay you back. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

5. When you pay the full cost for a prescription because you don't have your UnitedHealthcare plan member ID card with you

If you do not have your UnitedHealthcare plan member ID card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

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

7. 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.

- 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.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 8 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

Section 2.1 How and where to send us your request for payment

You may request us to pay you back by either calling us or 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 receipts for your records. **You must submit your Part C (medical) claim to us within 12 months** of the date you received the service, item, or Part B drug.

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

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 (myuhc.com/CommunityPlan) or call Customer Service and ask for the form.

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

Part D Prescription drug payment requests
UnitedHealthcare
PO Box 5250
Kingston, NY 12402-5250

Medical Claims payment requests
UnitedHealthcare
PO Box 5250
Kingston, NY 12402-5250

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 or drug

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.

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- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for the service. If you have already paid for the service or drug, we will mail your reimbursement to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
 - If we decide that the medical care or drug is **not** covered, or you did **not** follow all the rules, we will not pay for the care or drug. 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 the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment, 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 the details on how to make this appeal, go to Chapter 8 of this document.

Chapter 7

Your rights and responsibilities

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

Section 1.1 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. This information is available for free in other languages. 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 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. 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.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, 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**.

Section 1.1 Usted tiene derecho a recibir información sobre la organización, sus servicios, sus profesionales y proveedores, y los derechos y responsabilidades de los miembros. Debemos proporcionar la información de una forma que le resulte conveniente (en idiomas distintos al inglés, en braille, en letra grande u otros formatos alternativos, etc.)

Para obtener información de una forma que le resulte conveniente, llame a Servicio al Cliente (los números de teléfono están impresos en la contraportada de esta guía).

Nuestro plan cuenta con personas y servicios gratuitos de interpretación 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 brindarle información en braille, en letra grande u otro formato alternativo sin costo, si es necesario. Se nos exige que le suministremos la información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de una forma que le resulte conveniente, llame a Servicio al Cliente (los números de teléfono están impresos en la contraportada de esta guía).

Si tiene alguna dificultad para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llame para presentar una queja formal a Servicio al Cliente (los números de teléfono están impresos 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 el Servicio al Cliente. Los usuarios de TTY deben llamar al **1-877-486-2048**.

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

You have the right to choose a Primary Care Provider (PCP) in the plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to network providers.

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. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 8 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 including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it 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. 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 NOTICES OF PRIVACY PRACTICES

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

Effective January 1, 2022.

By law, we¹ must protect the privacy of your health information (“HI”). We must send you this notice. It tells you:

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

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

- HI is information about your health or health care services. We have the right to change our privacy practices for handling HI. If we change them, we will notify you by mail or e-mail. We will also post the new notice at this website (myuhc.com/CommunityPlan).

We will notify you of a breach of your HI. We collect and keep your HI to run our business. HI may be oral, written or electronic. We limit employee and service provider access to your HI. We have safeguards in place to protect your HI.

How We Collect, Use, and Share Your Information

We collect, use, and share your HI with:

- You or your legal representative.
- Government agencies.

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

- **For Payment.** We may collect, use, and share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may collect, use, and share your HI with your providers to help with your care.
- **For Health Care Operations.** We may suggest a disease management or wellness program. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** We may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.
- **For Underwriting Purposes.** We may collect, use, and share your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may collect, use, and share your HI to send you appointment reminders and information about your health benefits.

- **For Communications to You.** We may send you emails with certain health information via unencrypted methods. There is some risk of disclosure or interception of the contents of these communications.

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

- **As Required by Law.**
- **To Persons Involved with Your Care.** This may be to a family member in an emergency. This may happen if you are unable to agree or object. If you are unable to object, we will use our best judgment. If permitted, after you pass away, we may share HI with family members or friends who helped with your care.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings.** To answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.
- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.
- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** To study disease or disability.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death, or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates** if needed to give you services. Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.
- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
 1. Alcohol and Substance Abuse
 2. Biometric Information
 3. Child or Adult Abuse or Neglect, including Sexual Assault
 4. Communicable Diseases
 5. Genetic Information

6. HIV/AIDS
7. Mental Health
8. Minors' Information
9. Prescriptions
10. Reproductive Health
11. Sexually Transmitted Diseases

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

Your Rights

You have the following rights.

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. You can have your record sent to a third party. We may send you a summary. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website, (myuhc.com/CommunityPlan).

Using Your Rights

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-800-514-4911**, or TTY/RTT **711**.

- **To ask that we correct or amend** your HI. Depending on where you live, you can also ask us to delete your HI. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.
- **To Submit a Written Request.** Mail to:
UnitedHealthcare Privacy Office
MN017-E300
PO Box 1459
Minneapolis MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

¹This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus South Central Insurance Company; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus Wisconsin Insurance; Health Plan of Nevada, Inc.; Optimum Choice, Inc.; Oxford Health Plans (NJ), Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of River Valley; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; and UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to uhc.com/privacy/entities-fn-v2-en.

FINANCIAL INFORMATION PRIVACY NOTICE

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

Effective January 1, 2022

We² protect your “personal financial information” (“FI”). FI is non-health information. FI identifies you and is generally not public.

Information We Collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and Security

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

Questions About This Notice

Please **call the toll-free member phone number on health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-800-514-4911**, or TTY/RTT **711**.

²For purposes of this Financial Information Privacy Notice, “we” or “us” refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Corporation.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; gethealthinsurance.com Agency, Inc. Genoa Healthcare, LLC; Golden Outlook, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; Optum Health Care Solutions, Inc.; OptumHealth Holdings, LLC; Optum Labs, LLC; Optum Networks of New Jersey, Inc.; Optum Women’s and Children’s Health, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, Inc.; Renai Health IPA, LLC’ Renai Health Management, LLC; Sanvello Health, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does

not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to [uhc.com/privacy/entities-fn-v2-en](https://www.uhc.com/privacy/entities-fn-v2-en).

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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 UnitedHealthcare Dual Complete® ONE (HMO D-SNP), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.**
 - You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - Chapters 3 and 4 provide information regarding medical services. Chapter 5 provides information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.**
 - Chapter 8 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 8 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

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. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what 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.
- **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 Division of Medical Assistance and Health Services. For details about this organization and how to contact it, go to Chapter 2, Section 6.

Section 1.6 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 8 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 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.**
- 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.
 - Chapter 5 gives the details about your coverage for Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, 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 plan member ID card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions 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:
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For **UnitedHealthcare Dual Complete® ONE (HMO D-SNP)** members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- **If you move outside of our plan service area, you cannot remain a member of our plan.**
- **If you move within our service area, we still 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 8

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

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

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

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

Section 1.2 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 “integrated organization determination” or “coverage determination” or “at-risk determination,” and “Independent review organization” instead of “Independent Review Entity.”
- It also uses abbreviations as little as possible.

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

Section 2 Where to get more information and personalized 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 and website URLs in Chapter 2, Section 3 of this document.

Medicare

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

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to also get information directly from 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 visit the Medicare website ([medicare.gov](https://www.medicare.gov)).

You can get help and information from Medicaid

For more information and help in handling a problem, you can also contact Medicaid.

Here are two ways to get information directly from Medicaid:

- You can call **1-800-701-0710**, 8 a.m. to 5 p.m. ET, Monday–Friday. TTY users should call **711**.
- You can visit the Medicaid website (state.nj.us/humanservices/dmahs/).

Section 3 Understanding Medicare and Medicaid complaints and appeals in our plan

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

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

Problems about your benefits

Section 4 Coverage decisions and appeals

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

Is your problem or concern about your benefits or coverage?

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

Yes. Go on to the next section of this chapter, **Section 5, “A guide to the basics of coverage decisions and appeals.”**

No. Skip ahead to **Section 11** at the end of this chapter, **“How to make a complaint about quality of care, waiting times, customer service, or other concerns.”**

Section 5 A guide to the basics of coverage decisions and appeals

Section 5.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage, including payment. This is the process you use 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 services

A coverage decision is a decision we make about your benefits and coverage for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. 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 a medical service 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. In some cases, we might decide a service or drug 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 service 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 do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an Independent Review Entity that is not connected to us.

- Appeals for medical services and Part B drugs will be automatically sent to the Independent review organization for a Level 2 appeal — you do not need to do anything. The independent review organization will mail you a notice to confirm they received your Level 2 appeal. For Part D drug appeals, if we say no to all or part of your appeal to you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.

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

Section 5.2 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 or other health care provider 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 [cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf).
 - For medical care, your doctor or other health care provider 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.
 - If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you may need to name your doctor or other prescriber as your representative to act on your behalf.
 - For Part D or Medicaid prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **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 other 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 [cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1969.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1969.pdf) or on our website at myuhc.com/CommunityPlan.) The form gives that person permission to act on your behalf. It must be signed by you and by the person 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 5.3 Which section of this chapter gives the details for your situation?

There are four 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 6** of this chapter, “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter, “Your Part D and Medicaid prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter, “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter, “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (This section applies to these services only: 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, call Customer Service. You can also get help or information from government organizations such as your SHIP.

Section 6 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 6.1 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 your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: **Medical Benefits Chart (what is covered)**. To keep things simple, we generally refer to “medical care coverage” or “medical care” which includes medical items

and services as well as Medicare Part B prescription drugs. 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 our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other health care provider wants to give you, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe our plan should cover, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You 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 6.3.**

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

Section 6.2 Step-by-step: How to ask for a coverage decision

Legal Term: 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, 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 care you have not yet 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 10 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 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 10 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 6.3 Step-by-step: How to make a Level 1 appeal

Legal Term: 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. 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 6.2 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.** You may also ask for an appeal by calling us. 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 free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

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

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.

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



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

- When we are 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 6.4 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. (For more

information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

- 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 6.4 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, or within 7 calendar days if your request is for a Medicare Part B prescription drug, after we receive your appeal.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**
- If we say no to part or all of what you asked for, we will send you a letter.
 - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
 - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 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.

- If your problem is about a service or item that is usually **covered by Medicare**, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that is usually **covered by Medicaid**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you will automatically get a Level 2 appeal with the Independent review organization. You can also ask for a review by the state’s Independent Utilization Review Organization (IURO), and/or a Fair Hearing with the state.

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

- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the Independent review organization.

- If your problem is about a service that is usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after receiving the plan’s decision letter or by the intended effective date of the action, whichever is later.

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



Step 1: The Independent review organization reviews your appeal.

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

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

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

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

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



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

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

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must:
 - authorize the medical care coverage **within 72 hours** or

- provide the service within **14 calendar days** after we receive the Independent review organization's decision for **standard requests** or
 - provide the service **within 72 hours** from the date we receive the Independent review organization's decision for **expedited requests**.
 - **If the Independent review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must:
 - authorize or provide the Medicare Part B prescription drug **within 72 hours** after we receive the Independent review organization's decision for **standard requests** or
 - **within 24 hours** from the date we receive the Independent review organization's decision for **expedited requests**.
 - **If this organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.") In this case, the independent review organization will send you a letter:
 - Explaining its decision.
 - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Telling you how to file a Level 3 appeal.
 - If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you get after your Level 2 appeal.
 - The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator.
- Section 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

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



Step 1: You can ask for an IURO appeal and/or a Fair Hearing with the state.

- Level 2 of the appeals process for services that are usually covered by Medicaid gives you the option to request a review by the state's Independent Utilization Review Organization (IURO), as well as the option to request a Fair Hearing with the state. You must ask for a Fair Hearing in writing **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

How do I request an IURO appeal?

- The Independent Utilization Review Organization (IURO) is an independent organization that is hired by the State of New Jersey's Department of Banking and Insurance (DOBI). This organization is not connected with us, and it is not a government agency. This organization is chosen by the DOBI to serve as an independent reviewer for medical appeals, and the DOBI administers the IURO appeal process. A review by the IURO is also sometimes called an "IURO appeal" or an "External appeal".

- The IURO appeal process is optional. You can request an IURO appeal, and wait to receive the IURO's decision, before you request a Fair Hearing. Or, you can request an IURO appeal and a Fair Hearing at the same time (the requests are made to two different organizations). You do not need request an IURO appeal to request a Fair Hearing.
- You can request an IURO appeal yourself, or it can be requested by your Authorized Representative (which includes your provider, if they are acting on your behalf with your written consent).
- You can request an IURO appeal by filling out the External Appeal Application form. A copy of the External Appeal Application form will be sent to you with the decision letter for your Level 1 appeal. You must send this form to the following address **within 60 calendar days** of the date on the decision letter for your Level 1 appeal:

Maximus Federal - NJ IHCAP
3750 Monroe Avenue, Suite 705
Pittsford, New York 14534
Office: 888-866-6205
Fax: 585-425-5296
Email: Stateappealseast@maximus.com

You may also fax the form to **585-425-5296**, or email a copy of the form to Stateappealseast@maximus.com.

- If you are appealing because we told you we were going to stop or reduce services or items that you were already getting and you want to keep those services or items during your IURO appeal, you must request the IURO appeal **within 10 calendar days** of the date on the decision letter for your Level 1 appeal.
- If the IURO reviews your case, it will reach a decision **within 45 calendar days** (or sooner, if your medical condition makes it necessary). If your IURO appeal is a "fast" appeal, the IURO will reach a decision **within 48 hours**.
- If you have questions about the IURO appeal process and/or need assistance with your application, you can call the New Jersey Department of Banking and Insurance at **1-888-393-1062** or **609-777-9470**.

How do I request a Fair Hearing?

- You must ask for a Fair Hearing in writing **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.
- If you ask for an expedited, or "fast" Fair Hearing, and you meet all of the requirements for a "fast" hearing, a decision will be made within 72 hours of the agency's receipt of your hearing request.
- If you are appealing because we told you we were going to stop or reduce services or items that you were already getting and you want to keep those services or items during your Fair Hearing, you must request that your benefits be continued **in writing** on your Fair Hearing request, and you must send your request **within 10 calendar days** of the date on the decision letter for your Level 1 appeal.

Or, if you asked for an IURO appeal and received a decision before requesting a Fair Hearing, you must send this written request **within 10 calendar days** of the date on the letter informing you of the decision on your IURO appeal.

Please note that if you ask to have your services or items continue during a Fair Hearing and the final decision is not in your favor, you may be required to pay for the cost of the services or items.



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

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

- If the Fair Hearing office says yes to part or all of a request for a medical item or service, we must authorize or provide the service or item within 72 hours after we receive the decision from the Fair Hearing office.
- If the Fair Hearing office says no to part or all of your appeal, they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision” or “turning down your appeal.”)

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

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

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

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

Section 6.5 What if you are asking us to pay you back for a bill you have received for medical care?

If you have already paid for a Medicaid service or item covered by the plan, 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 for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Asking for reimbursement is asking for a coverage decision from us.

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

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this coverage decision. We will check to see if the medical care you paid for is a covered service. 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 the cost within 60 calendar days after we receive your request.

- **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 services 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 30 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 health care provider within 60 calendar days.

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

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs.

To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, and restrictions, please see Chapters 5.

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time. We also use the term “drug list” instead of “List of Covered Drugs” or “Formulary.”
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term: An initial coverage decision about your Part D or Medicaid drugs is called a “**coverage determination.**”

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

- Asking to cover a Part D drug that is not on the plan’s List of Covered Drugs. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 What is an exception?

Legal Term: Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “**formulary exception.**”

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “**formulary exception.**”

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

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

- 1. Covering a Part D drug for you that is not on our Drug List.**
- 2. Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 7.4 **Step-by-step: How to ask for a coverage decision, including an exception**

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



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

“Standard coverage decisions” are made within **72 hours** after we receive your doctor’s statement.

“Fast coverage decisions” are made within **24 hours** after we receive your doctor’s statement.

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

- You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber’s support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
 - Tells you how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.



Step 2: Request a “standard coverage decision” or a “fast coverage decision.”

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Chapter 2 has contact information.

To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

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

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



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

Deadlines for a “fast coverage decision”

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

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

- We must give you our answer within 72 hours after we receive your request.
 - For exceptions, we will give you our answer within 72 hours after we receive your doctor’s supporting. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor’s statement supporting your request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a “standard” coverage decision about payment for a drug you have already bought

- We must give you our answer within 14 calendar days after we receive your request.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- If our answer is yes to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.



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

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

Section 7.5 Step-by-step: How to make a Level 1 appeal

Legal Term: An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”

A “fast appeal” is also called an “**expedited redetermination.**”



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

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

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 of this chapter.



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

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at (1-800-514-4911, 8 a.m.–8 p.m.: 7 Days, October–March; Monday–Friday, April–September)**
- Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.

- **You must make your appeal request within 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 in your appeal and add more information.** You and your doctor may add more information to support your appeal.



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

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast appeal”

- For fast appeals, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires us to. o If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 7.6 explains the Level 2 appeal process.
- If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a “standard” appeal for a drug you have not yet received

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

Deadlines for a “standard appeal” about payment for a drug you have already bought

- We must give you our answer within 14 calendar days after we receive your request.
- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- If our answer is yes to part or all of what you requested, we are also required to make payment to you within 30 calendar days after we receive your request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.



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

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

Section 7.6 Step-by-step: How to make a Level 2 appeal

Legal Term: The formal name for the “Independent review organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

The **independent review organization is an independent organization hired by Medicare.** It 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: You (or your representative or your doctor or other prescriber) must contact the Independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the Independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding “at-risk” determination under our drug management program, we will automatically forward your claim to the IRE.
- 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.



Step 2: The independent review organization reviews your appeal.

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

Deadlines for “fast appeal”

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

Deadlines for “standard appeal”

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.



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

For “fast appeals”:

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

For “standard appeals”:

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

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called “upholding the decision” 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 drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.



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

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

Section 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

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

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

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

Section 8.1 During your inpatient hospital stay, you 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, 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 **[cms.gov/Medicare/Medicare-General-information/BNI/HospitalDischargeappealNotices](https://www.cms.gov/Medicare/Medicare-General-information/BNI/HospitalDischargeappealNotices)**.

Section 8.2 **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, call Customer Service. Or call the **State Health Insurance Assistance Program (SHIP)**, 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 8.4** of this chapter.

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 [cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices](https://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 (“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 our plan 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.**
- 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 says 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 8.3 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 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.**
- 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 10** of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.4 What if you miss the deadline for making your Level 1 appeal?

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 start your Level 1 appeal of your hospital discharge. 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 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 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 the costs of care you have received since the date when we said your coverage would end. (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 we say 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 11** 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 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. If there are coverage limitations, these could limit 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 you how to start a Level 3 appeal, 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 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

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

Section 9.1 This section is about only three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your covered 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 for your care.**

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

Section 9.2 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 decision to stop care.

Section 9.3 **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, call Customer Service. Or call the **State Health Insurance Assistance Program (SHIP)**, 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 review. 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.

Your deadline for contacting this organization.

- 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 9.5** of this chapter.



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 information that our plan has given to them.
- By the end of the day the reviewers told 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.**
- There may be limitations on your covered services.

What happens if the reviewers say no?

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



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

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

Section 9.4

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 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.
- There may be coverage limitations that apply.

What happens if the review organization says no?

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



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

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

Section 9.5 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 we 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 the costs of care you have received since the date when we said your coverage would end. (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 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 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 11** 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 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. If there are coverage limitations, these could limit 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 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

Section 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

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

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

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
 - If we decide not to appeal, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge’s or attorney adjudicator’s decision.
 - If we decide to appeal, 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 service 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 service within 60 calendar days after receiving the Council’s decision.
 - If we decide to appeal the decision, we will let you know in writing.
 - **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.
-

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

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

Section 10.2 Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

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

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
 - **If the answer is no, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.
-

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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

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

Section 11.1 What kinds of problems are handled by the complaint process?

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

| Complaint | Example |
|---|---|
| Quality of your medical care | <ul style="list-style-type: none">• Are you unhappy with the quality of the care you have received (including care in the hospital)? |
| Respecting your privacy | <ul style="list-style-type: none">• Did someone not respect your right to privacy or share confidential information? |
| Disrespect, poor customer service, or other negative behaviors | <ul style="list-style-type: none">• 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 | <ul style="list-style-type: none">• Are you having trouble getting an appointment, or waiting too long to get it?• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan?<ul style="list-style-type: none">– Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription. |
| Cleanliness | <ul style="list-style-type: none">• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office? |
| Information you get from us | <ul style="list-style-type: none">• Did we fail to give you a required notice?• Is our written information hard to understand? |

| Complaint | Example |
|---|--|
| Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals) | If you have asked for a coverage decision or made an appeal and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: <ul style="list-style-type: none">• 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 services or drugs that were approved; you can make a complaint.• You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint. |

Section 11.2 How to make a complaint

Legal Terms:

- A “**Complaint**” is also called a “**grievance.**”
- “**Making a complaint**” is also called “**filing a grievance.**”
- “**Using the process for complaints**” is also called “**using the process for filing a grievance.**”
- A “**fast complaint**” is also called an “**expedited grievance.**”

Section 11.3 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.
- When you file a complaint, we will address it 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. If we do not accept your complaint in the whole or in part, our written decision will explain why it was not accepted, and will tell you about options you may have. The address and fax numbers for filing complaints are located in Chapter 2 under "How to contact us when you are making a complaint about your medical care" OR "How to contact us when you are making a complaint about your Part D prescription drugs or Medicaid over-the-counter prescription drugs".

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



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

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

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

Or

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

Section 11.5 You can also tell Medicare and Medicaid about your complaint

You can submit a complaint about UnitedHealthcare Dual Complete® ONE (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to **[medicare.gov/MedicareComplaintForm/home.aspx](https://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**.

You can also contact Medicaid. Here are two ways to get information directly to Medicaid:

- You can call the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) at **1-800-701-0710**, 8 a.m.–5 p.m. ET, Monday–Friday. TTY users should call **711**.
- You can visit the Medicaid website (**state.nj.us/humanservices/dmahs/**).

Chapter 9

Ending your membership in the plan

Section 1 Introduction to ending your membership in our plan

Ending your membership in **UnitedHealthcare Dual Complete® ONE (HMO D-SNP)** 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 prescription drugs until your membership ends.

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

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15–December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- Choose any of the following types of Medicare 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.
 - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without “creditable” prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this document).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership 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
- OR
- 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.

If you receive “Extra Help” from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3 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 2.4 In certain situations, you can end your membership during a Special Enrollment Period

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

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

- Usually, when you have moved
- If you have NJ FamilyCare (Medicaid)
- If you are eligible for “Extra Help” with paying for your Medicare prescriptions
- 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)
- **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.

Note: Section 2.1 tells you more about the special enrollment period for people with Medicaid.

- **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.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you receive “Extra Help” from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

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

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 **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 2023** 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: |
|---|--|
| <ul style="list-style-type: none">• Another Medicare health plan. | <ul style="list-style-type: none">• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from UnitedHealthcare Dual Complete® ONE (HMO D-SNP) when your new plan's coverage begins. |
| <ul style="list-style-type: none">• Original Medicare with a separate Medicare prescription drug plan. | <ul style="list-style-type: none">• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month.• You will automatically be disenrolled from UnitedHealthcare Dual Complete® ONE (HMO D-SNP) when your new plan's coverage begins. |

| If you would like to switch from our plan to: | This is what you should do: |
|--|---|
| <ul style="list-style-type: none"> • Original Medicare without a separate Medicare prescription drug plan. <ul style="list-style-type: none"> – If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. – If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later. | <ul style="list-style-type: none"> • Send us a written request to disenroll. 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 UnitedHealthcare Dual Complete® ONE (HMO D-SNP) when your coverage in Original Medicare begins. |

If you disenroll from this plan and make any of the choices listed above, you will be enrolled into our affiliated NJ FamilyCare plan, UnitedHealthcare Community Plan, for your NJ FamilyCare (Medicaid) benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another FIDE SNP plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at **1-800-701-0710 (TTY 711)**.

For questions about your NJ FamilyCare (Medicaid) benefits, contact the Division of Medical Assistance and Health Services at **1-800-701-0710 (TTY 711)**, 8:30 a.m.–4:45 p.m. local time, Monday–Friday. Ask how joining another plan or returning to Original Medicare affects how you get your NJ FamilyCare (Medicaid) coverage.

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

Until your membership in **UnitedHealthcare Dual Complete® ONE (HMO D-SNP)** ends, and your new Medicare and Medicaid coverage begins, you must continue to get your medical care and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

Section 5 UnitedHealthcare Dual Complete® ONE (HMO D-SNP) must end your membership in the plan in certain situations

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

UnitedHealthcare Dual Complete® ONE (HMO D-SNP) must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you are no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. We must notify you in writing that you have a 6 month grace period to regain eligibility before you are disenrolled. For more information on the grace period, please see Chapter 4, section 2.1.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, 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 lie or withhold information about other insurance you have that provides prescription drug coverage.
- 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**, at **1-800-514-4911**, 8 a.m.–8 p.m.: 7 Days, October–March; Monday–Friday, April–September.

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

UnitedHealthcare Dual Complete® ONE (HMO D-SNP) 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 10

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 nondiscrimination

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, and 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 <https://hhs.gov/ocr/index>.

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, UnitedHealthcare Dual Complete® ONE (HMO D-SNP), 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 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 5 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.

Section 6 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 7 2022 Enrollee Fraud & Abuse Communication

2022 Enrollee Fraud & Abuse Communication

How you can fight healthcare fraud

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

Here are some examples of potential Medicare fraud cases:

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

To report a potential case of fraud in a Medicare benefit program, call UnitedHealthcare Dual Complete® ONE (HMO D-SNP) Customer Service at **1-800-514-4911 (TTY 711)**, 8am-8pm: 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 (**1-800-633-4427**). The Medicare fax number is **1-717-975-4442** and the website is **www.medicare.gov**.

Section 8 Commitment of coverage decisions

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. UnitedHealthcare:

1. Does not specifically reward Clinical Staff and Physicians making these decisions for issuing non-coverage (denial) decisions;
2. Does not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services; and
3. Does 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 9 Renew Active® Terms and Conditions

Eligibility Requirements

- Only members enrolled in a participating Medicare Plan insured by UnitedHealthcare Insurance Company (“UnitedHealthcare”) and affiliates are eligible for the Renew Active program (“Program”), which includes, without limitation, access to standard fitness memberships at participating gyms/fitness locations, online fitness and cognitive providers, digital communities, events, classes and discounts for meal delivery at no additional cost.
- By enrolling in the Program, you hereby accept and agree to be bound by these Terms and Conditions.

Enrollment Requirements

- Membership and participation in the Program is voluntary.
- You must enroll in the Program according to the instructions provided on this website. Once enrolled, you must obtain your confirmation code and use it when signing up for any Program services. Provide your confirmation code when visiting a participating gym/fitness location to receive standard membership access at no additional cost, registering with an online fitness and/or cognitive providers, joining the Fitbit® Community for Renew Active, and to gain access to included discounts. Please note, that by using your confirmation code, you are electing to disclose that you are a Renew Active member with a participating UnitedHealthcare Medicare plan.
- Program enrollment is on an individual basis and the Program’s waived monthly membership rate for standard membership services at participating gyms and fitness locations is only applicable to individual memberships.

- You are responsible for any and all non-covered services and/or similar fee-based products and services offered by Program service providers (including, without limitation, gym/fitness centers, digital fitness offerings, digital cognitive providers, Fitbit, and other third party service offerings made available through the Program), including, without limitation, fees associated with personal training sessions, specialized classes, enhanced facility membership levels beyond the basic or standard membership level, and meal delivery.
- Fitness membership equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Access to gym and fitness location network may vary by location and plan.

Liability Waiver

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

Other Requirements

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

Data Requirements

- Optum (the Program administrator) and/or your service provider will collect and electronically send and/or receive the minimum amount of your personal information required in order to facilitate the Program in accordance with the requirements of applicable laws, including privacy laws. Such required personal information includes, but is not limited to, program confirmation code, gym/fitness location/provider membership ID, activity year and month, and monthly visit count. By enrolling in the Program, you authorize Optum to request, and each service provider to provide, such personal information.

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Section 10 Fitbit® Terms and Conditions

Your use of any Fitbit device or service is voluntary. If you have a medical or heart condition, you should consult your doctor before using the Fitbit Service, engaging in an exercise program, or changing your diet. Availability of the Fitbit benefit varies by plan/market. Refer to Chapter 4, Section 2.1 for more details. Fitbit, the Fitbit logo, and related marks and logos are trademarks of Google LLC and/or its affiliates.

Chapter 11

Definitions of important words

Chapter 11

Definitions of important words

Advance Directive—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. You have the right to give instructions about what is to be done if you are not able to make health 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.

Ambulatory Surgical Center—An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patient’s not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal—An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

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. There is no limit to the number of benefit periods.

Brand Name Drug—A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

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 special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2. A C-A SNP must have specific attributes that go beyond the provision of basic Medicare Parts A and B services and care coordination that is required of all Medicare Advantage Coordinated Care Plans, in order to receive the special designation and marketing and enrollment accommodations provided to C-SNPs

Clinical Research Study—A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Coinsurance—An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%). Enrollees of this plan are not required to pay any co-insurance.

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 drug. A copayment is a set amount, (for example \$10), rather than a percentage. Enrollees of this plan are not required to pay any co-payments.

Cost Sharing—Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received. Enrollees of this plan are not required to pay any deductibles, co-payments, or co-insurance.

Coverage Determination—A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this document.

Covered Drugs—The term we use to mean all of the prescription drugs covered by our plan.

Covered Services—The term we use 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 usually pay for custodial care, but this plan covers it.

Customer Service—A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Daily cost-sharing rate—A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in your plan is 30 days, then your “daily cost-sharing rate” is \$1 per day. You do not have any cost sharing under this plan.

Deductible—The amount you must pay for health care or prescriptions before our plan pays. You do not have any deductibles under this plan.

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.

Dual Eligible Individual—A person who qualifies for Medicare and Medicaid coverage.

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.

Exception—A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception). You may also request an exception if our plan requires you

to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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.

Generic Drug—A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

Home Health Aide—A person who provides services that 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).

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 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](https://www.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.

Institutional Special Needs Plan (SNP)—A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP)—A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Integrated Grievance - A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Integrated 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.

List of Covered Drugs (Formulary or “Drug List”)—A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS)—See “Extra Help”.

Managed Long Term Services and Supports (MLTSS)—Managed Long Term Services and Supports (MLTSS) is a program that provides Home and Community-Based services for members that require the level of care typically provided in a Nursing Facility, and allows them to receive necessary care in a residential or community setting. MLTSS services include (but are not limited to): assisted living services; cognitive, speech, occupational, and physical therapy; chore services; home delivered meals; residential modifications (such as the installation of ramps or grab bars); vehicle modifications; social adult day care; and non-medical transportation. MLTSS is available to members who meet certain clinical and financial requirements. For more information on MLTSS, call Customer Service (phone numbers are printed on the back cover of this booklet).

Medicaid (or Medical Assistance)—A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Emergency—A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Medically Accepted Indication—A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medically Necessary—Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare—The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period—The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan—Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP) In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare-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 as payment in full. (See Chapter 1, Section 3.2).

Network Pharmacy—A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider—“Provider” is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **“Network providers”** have an agreement with our plan to

accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called “plan providers.”

Original 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 Pharmacy—A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility—A provider or facility that does not have a contract with our plan to provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

PACE plan—A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) 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. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C—see “**Medicare Advantage (MA) Plan.**”

Part D—The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs—Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty—An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage. Enrollees of this plan are not required to pay any premiums.

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—Approval in advance to get services or certain drugs Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics—Medical devices including, but 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.

Providers—Doctors and other health care professionals that the state licenses to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.

Quality Improvement Organization (QIO)—A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quantity Limits—A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

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.

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 must 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 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.

Step Therapy—A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI)—A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits 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.

UnitedHealthcare Dual Complete® ONE (HMO D-SNP) Customer Service:



Call 1-800-514-4911

Calls to this number are free.

8am–8pm: 7 Days October–March; Monday–Friday April–September

Customer Service also has free language interpreter services available for non-English speakers.

TTY 711

Calls to this number are free.

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



myuhc.com/CommunityPlan

State Health Insurance Assistance Program (New Jersey SHIP)–Contact information



Call 1-800-792-8820

TTY 711



**Write: NJ State Health Insurance Assistance Program,
PO Box 807, Trenton, NJ 08625**



state.nj.us/humanservices/doas/services/ship/

State Health Insurance Assistance Program (New Jersey SHIP)

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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