Evidence of Coverage 2024

UnitedHealthcare® Group Medicare Advantage (HMO)
Group Name (Plan Sponsor): LOS RIOS COMMUNITY COLLEGE
Group Number: 141277

Toll-free **1-800-457-8506,** TTY **711**
8 a.m.-8 p.m. local time, Monday-Friday

retiree.uhc.com

United Healthcare®

Y0066_EOC_H0543_805_000_2024_C

January 1, 2024 - December 31, 2024

Evidence of Coverage

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

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

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

For questions about this document, please contact Customer Service at 1-800-457-8506. (TTY users should call 711). Hours are 8 a.m.-8 p.m. local time, Monday-Friday.

This plan, UnitedHealthcare® Group Medicare Advantage (HMO), is insured through UnitedHealthcare Insurance Company or one of its affiliates. (When this **Evidence of Coverage** says "we," "us," or "our," it means UnitedHealthcare. When it says "plan" or "our plan," it means UnitedHealthcare® Group Medicare Advantage (HMO).)

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

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. For more information, please call Customer Service at the number on your member ID card or the front of your plan booklet.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Comuníquese con nuestro número de Servicio al Cliente al número que se encuentra en su tarjeta de ID de miembro o en la portada de la guía de su plan.

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

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

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

- Your plan premium and cost-sharing;
- 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.

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

2024 Evidence of Coverage Table of Contents

Chapter 1

Getting started as a member

Section 1 Introduction

Section 1.1 You are enrolled in UnitedHealthcare® Group Medicare Advantage (HMO), which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, UnitedHealthcare® Group Medicare Advantage (HMO). We are required to cover all Part A and Part B services. However, cost-sharing and provider access in this plan differ from Original Medicare.

Our plan is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

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

Section 1.2 What is the Evidence of Coverage document about?

This **Evidence of Coverage** document tells you how to get your medical care 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.

When the Agreement is purchased by the Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

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

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

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

Section 1.3 Legal information about the Evidence of Coverage

This **Evidence of Coverage** is part of our contract with you about how the plan covers your care. Other parts of this contract include your enrollment form or your verbal or electronic election of our plan, 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 the plan between January 1, 2024 and December 31, 2024.

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

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

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

Section 2.1 Your eligibility requirements

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

- You meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor)
- You have both Medicare Part A and Medicare Part B
- **— and —** you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- **— and —** you are a United States citizen or are lawfully present in the United States

Section 2.2 Here is the plan service area for UnitedHealthcare® Group Medicare Advantage (HMO)

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

Our service area includes these counties in California: Alameda, Amador, Contra Costa, El Dorado, Fresno, Kern, Kings, Lake, Los Angeles, Madera, Marin, Mendocino, Merced, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Tehama, Tulare, Ventura, Yolo.

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

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

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

Section 2.3 U.S. Citizen or Lawful Presence

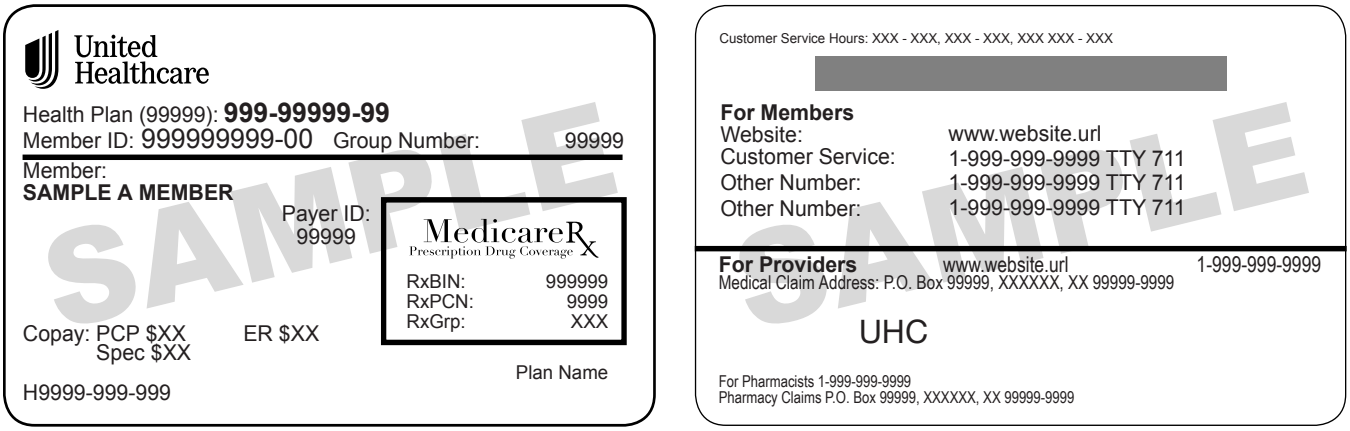
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify UnitedHealthcare® Group

Medicare Advantage (HMO) if you are not eligible to remain a member on this basis. UnitedHealthcare® Group Medicare Advantage (HMO) must disenroll you if you do not meet this requirement.

Section 3 Important membership materials you will receive

Section 3.1 Your UnitedHealthcare member ID card

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



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

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

Section 3.2 Provider Directory

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

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently

needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers.

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

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

Section 3.3 Pharmacy Directory

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 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 **Pharmacy Directory,** you can get a copy from Customer Service. You can also find this information on our website at retiree.uhc.com.

Section 3.4 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 under the Part D benefit included in our plan. 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. Medicare has approved the plan's 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. The Drug List we provide you 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. To get the most complete and current information about which drugs are covered, you can visit the plan's website (retiree.uhc.com) or call Customer Service.

Section 4 Your monthly costs for the plan

Your costs may include the following:

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

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of Medicare & You 2024 handbook, the section called "2024 Medicare Costs." If you need a copy you can download it from the Medicare website

(medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

Your former employer, union group or trust administrator (plan sponsor) is responsible for paying your monthly plan premium to UnitedHealthcare on your behalf. Your plan sponsor determines the amount of any retiree contribution toward the monthly premium for our plan. Your plan sponsor will notify you if you must pay any portion of your monthly premium for our plan.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D late enrollment penalty. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. (For members who must pay a late enrollment penalty, the amount of the penalty will be added to the bill we send to your plan sponsor.) When you first enroll in our plan, we let you know the amount of the penalty. Your Part D late enrollment penalty is considered part of your plan premium.

You will not have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
  - **Note:** Any notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.

- **Note:** The following are **not** creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount is $34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $34.70, which equals $4.86. This rounds to $4.90. This amount would be added **to the plan sponsor's monthly premium for someone with a Part D late enrollment penalty.**

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter

how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 5 More information about your monthly premium

Section 5.1 Can we change your monthly plan premium during the year?

Monthly plan premium changes and employer-sponsored benefit changes are subject to contractual arrangements between your plan sponsor and us, and as a result, monthly plan premiums generally do not change during the plan year. Your plan sponsor is responsible for notifying you of any monthly plan premium changes or retiree contribution changes (the portion of your monthly plan premium your plan sponsor requires you to pay) prior to the date when the change becomes effective.

However, in some cases, your plan sponsor may need to start paying or may be able to stop paying a Late Enrollment Penalty. (The Late Enrollment Penalty may apply if you had a continuous period of 63 days or more when you didn't have "creditable" prescription drug coverage.) This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If your plan sponsor currently pays the Part D late enrollment penalty and you become eligible for "Extra Help" during the year, your plan sponsor would no longer pay your penalty.
- 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.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

Section 6 Keeping your plan membership record up to date

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

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 and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

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

If any of this information changes, please let us know by calling Customer Service.

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

Section 7 How other insurance works with our plan

Other insurance

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

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

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

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

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

- If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

Chapter 2

Important phone numbers and resources

Section 1 UnitedHealthcare® Group Medicare Advantage (HMO) Contacts (how to contact us, including how to reach Customer Service)

How to contact our plan's Customer Service

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

Method	Customer Service - Contact Information
Call	**1-800-457-8506** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Write	UnitedHealthcare Customer Service Department P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	**retiree.uhc.com**

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. 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 or Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

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

Method	Coverage Decisions for Medical Care – Contact Information
Call	**1-800-457-8506** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	**711**

Method	Coverage Decisions for Medical Care – Contact Information
	Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Write	UnitedHealthcare P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	**retiree.uhc.com**

Method	Appeals for Medical Care – Contact Information
Call	**1-800-457-8506** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday For fast/expedited appeals for medical care: **1-877-262-9203** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Fax	**1-888-517-7113** For fast/expedited appeals for medical care only: **1-866-373-1081**
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6106, MS CA124-0157, Cypress, CA 90630-0016
Website	**retiree.uhc.com**

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
Call	**1-800-457-8506** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday For expedited coverage decisions for Part D prescription drugs only: **1-800-595-9532**

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
	Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, 7 days a week
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Write	OptumRx Prior Authorization Department P.O. Box 25183, Santa Ana, CA 92799
Website	**retiree.uhc.com**

Method	Appeals for Part D Prescription Drugs – Contact Information
Call	**1-800-457-8506** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday For fast/expedited appeals for Part D prescription drugs: **1-800-595-9532** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, 7 days a week
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Fax	For standard Part D prescription drug appeals: **1-866-308-6294** For fast/expedited Part D prescription drug appeals: **1-866-308-6296**
Write	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA124-0197, Cypress, CA 90630-0016
Website	**retiree.uhc.com**

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

You can make a complaint about us or one of our network providers, 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 9 **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).**

Method	Complaints about Medical Care – Contact Information
Call	**1-800-457-8506** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday For fast/expedited complaints about medical care: **1-877-262-9203** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Fax	**1-888-517-7113** For fast/expedited complaints about medical care only: **1-866-373-1081**
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6106, MS CA124-0157, Cypress, CA 90630-0016
Medicare Website	You can submit a complaint about UnitedHealthcare® Group Medicare Advantage (HMO) directly to Medicare. To submit an online complaint to Medicare, go to **medicare.gov/MedicareComplaintForm/home.aspx.**

Method	Complaints about Part D Prescription Drugs – Contact Information
Call	**1-800-457-8506** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday For fast/expedited complaints about Part D prescription drugs: **1-800-595-9532** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, 7 days a week
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Fax	For standard Part D prescription drug complaints: **1-866-308-6294**

Method	Complaints about Part D Prescription Drugs – Contact Information
	For fast/expedited Part D prescription drug complaints: **1-866-308-6296**
Write	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA124-0197, Cypress, CA 90630-0016
Medicare Website	You can submit a complaint about UnitedHealthcare® Group Medicare Advantage (HMO) directly to Medicare. To submit an online complaint to Medicare, go to **medicare.gov/MedicareComplaintForm/home.aspx.**

Where to send a request asking us to pay for our share of the cost for medical care 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 7 **(Asking us to pay our share of 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 9 **(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))** for more information.

Method	Payment Requests – Contact Information
Call	**1-800-457-8506** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
TTY	**711** Calls to this number are free. Hours of Operation: 8 a.m.-8 p.m. local time, Monday-Friday
Write	Medical claims payment requests: UnitedHealthcare P.O. Box 30968, Salt Lake City, UT 84130-0968 Part D prescription drug payment requests: OptumRx P.O. Box 650287, Dallas, TX 75265-0287
Website	**retiree.uhc.com**

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

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations, including us.

Method	Medicare – Contact Information
Call	**1-800-MEDICARE,** or **1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Website	**medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: □ **Medicare Eligibility Tool:** Provides Medicare eligibility status information. □ **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Because your coverage is provided by a plan sponsor, you will not find UnitedHealthcare® Group Medicare Advantage (HMO) plans listed on medicare.gov. These tools provide an **estimate** of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about UnitedHealthcare® Group Medicare Advantage (HMO): □ **Tell Medicare about your complaint:** You can submit a complaint about UnitedHealthcare® Group Medicare Advantage (HMO) directly

Method	Medicare – Contact Information
	to Medicare. To submit a complaint to Medicare, go to medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

Section 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In your state, the SHIP is called California Health Insurance Counseling & Advocacy Program (HICAP).

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

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

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

Method	State Health Insurance Assistance Program (SHIP) – Contact Information California California Health Insurance Counseling & Advocacy Program (HICAP)
Call	**1-800-434-0222**
TTY	**1-800-735-2929**

Method	State Health Insurance Assistance Program (SHIP) – Contact Information California California Health Insurance Counseling & Advocacy Program (HICAP)
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	2880 Gateway Oaks Dr, STE 200, Sacramento, CA 95833
Website	**http://www.aging.ca.gov/hicap/**

Section 4 Quality Improvement Organization

There is a designated Quality Improvement Organization serving Medicare beneficiaries in each state. For California, the Quality Improvement Organization is called Livanta BFCC-QIO Program.

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

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

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

Method	Quality Improvement Organization (QIO) – Contact Information California Livanta BFCC-QIO Program
Call	**1-877-588-1123** **9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, weekends and holidays**
TTY	**1-855-887-6668** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	10820 Guilford RD, STE 202, Annapolis Junction, MD 20701
Website	**www.livantaqio.com**

Section 5 Social Security

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

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

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

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

Section 6 Medicaid

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

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

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

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

Method	State Medicaid Program – Contact Information California Medi-Cal - Managed Care Operations Division Department of Health Care Services (Medicaid)
Call	**1-800-430-4263** **8 a.m. - 5 p.m. PT, Monday - Friday**
TTY	**1-800-430-7077** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	P.O. Box 989009, West Sacramento, CA 95798-9850
Website	**https://www.healthcareoptions.dhcs.ca.gov/**

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/5-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

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Please call the customer service number in Chapter 2 Section 1. Our Customer Service Advocates can help get your copayment amount corrected.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan may pay a portion of the costs of brand name drugs in the coverage gap. The 70% discount and any portion paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

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

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

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

Method	AIDS Drug Assistance Program (ADAP) – Contact Information Department of Health Services - ADAP
Call	1-844-421-7050

Method	AIDS Drug Assistance Program (ADAP) – Contact Information Department of Health Services - ADAP
	8 a.m.-5 p.m. local time, Monday-Friday
Website	**https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_medpartd.aspx**

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition or disabilities. Each state has different rules to provide drug coverage to its members.

In California, the State Pharmaceutical Assistance Program is Department of Health Services - ADAP

Method	State Pharmaceutical Assistance Programs – Contact Information California Department of Health Services - ADAP
Call	**1-844-421-7050** **8 a.m.-5 p.m. local time, Monday-Friday**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	Insurance Assistance Section, P.O. Box 997426, MS 7704, Sacramento, CA 95899-7426
Website	**https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_medpartd.aspx**

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

Section 9 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse or domestic partner) have medical or prescription drug coverage through another employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current coverage will work with our plan. You can also call Customer Service if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period.

Chapter 3

Using the plan for your medical services

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

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

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

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

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

As a Medicare health plan, UnitedHealthcare® Group Medicare Advantage (HMO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

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

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

or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
- Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

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

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

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

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

What is a PCP?

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

What types of providers may act as a PCP?

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

What is the role of my PCP?

Your relationship with your PCP is an important one because your PCP is responsible for your routine health care needs, for the coordination of all covered services provided to you, for maintaining a central medical record for you, and for ensuring continuity of care. If you need an appointment with a network specialist or other network provider who is not your PCP, you must obtain a referral from your PCP.

How do you choose your PCP?

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

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

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

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

Changing your PCP

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

If you want to change your PCP within your contracted medical group/IPA, 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.

If you want to change to a PCP who is with a different contracted medical group/IPA, call Customer Service. If the new PCP is accepting additional plan members, and your request is received on or before the 24th of the month, the transfer will become effective on the first day of the following month. If your request is received after the 24th of the month, the transfer will become effective the first day of the second month following your request. For example, if we receive your change request on July 24th, your change is effective on August 1. If we receive your change request on July 25th, your change is effective on September 1. You will receive a new UnitedHealthcare member ID card that shows this change.

Section 2.2 What kinds of medical care 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 as long as you get them from a network provider.

- 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.

If the network specialist wants you to come back for more care, please make sure those services will be covered services, by checking first with your PCP to make sure that your referral will extend to the additional care.

Neither the plan nor Medicare will pay for services, supplies, treatments, surgeries, and/or drug therapies for which a referral is required, but was not obtained from your PCP or us, except for emergency services, urgently needed services, out-of-area dialysis and post-stabilization care services, or when you have a prior authorization for an out-of-network provider.

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

When you select a PCP it is important to remember that your PCP will choose the network specialist to whom you will be referred based upon his or her referring practices and hospital affiliation. The presence of a particular network specialist in this directory does not mean that your PCP will refer you to that provider.

How to access your behavioral/mental health benefit

If you would like to receive a referral for behavioral/mental health services, please contact

Customer Service at the number listed on your UnitedHealthcare member ID card. Depending on your provider, you will be referred back to your PCP or to United Behavioral Health to access these benefits.

If you change your PCP to one who is in a different medical group/IPA, any referrals for behavioral/mental health services you previously received may no longer be valid. In this situation, you will need to ask your new PCP for a new referral, which may require further evaluation. In some cases,

the request for a new referral will need to have prior authorization from your medical group/IPA or us.

Since your PCP is responsible for the coordination of all of your health care needs, it is important that you notify him or her if you wish to continue to receive behavioral/mental health services from a provider who was affiliated with your previous PCP or medical group/IPA.

If you continue to receive behavioral/mental health services without a new referral from your new PCP, you may be financially responsible for the cost of those services. In certain circumstances, we may authorize continued care.

Your medical group/IPA may also choose to have you access your behavioral/mental health benefit directly through United Behavioral Health. When you call United Behavioral Health, you will speak with a representative who will check your eligibility and gather basic information about you and your situation. Depending on the help you need, a clinician may then talk with you about the problem you are experiencing and assess which provider and treatment would be appropriate for your situation. If you are referred to a behavioral/mental health provider, you will be authorized for a specific number of visits for a specified period of time. You may also call to receive information about **network practitioners,** subspecialty care and obtaining care after normal office hours.

Confidentiality is maintained, so please be assured that personal information you discuss with their staff will be kept strictly confidential.

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

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.

- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

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

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

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 three exceptions described in Section 1.2 of this chapter. For information about getting out-of-network care when you have a medical emergency or urgent need for care, please see Section 3 in this chapter.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for

additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

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

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

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

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

What are "urgently needed services"?

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

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

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

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

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

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

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 **(Asking us to pay our share of a bill you have received for covered medical services or drugs)** for information about what to do.

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

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

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

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

Section 5.1 What is a "clinical research study"?

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

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for in-network cost-sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will

reimburse the difference between what you paid and the in-network cost-sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan. Note: If you are not entitled to Medicare Part A coverage, neither Medicare nor the plan will pay the Part A costs related to a Medicare-covered clinical research study.

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

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

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

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

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

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

Note: If you are not entitled to Medicare Part A coverage, neither Medicare nor the plan will pay the Part A related costs related to a Medicare-covered clinical research study.

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost-sharing in Original Medicare and your in-network cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost-sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

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

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

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

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at: medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

Section 6.2 Receiving care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to **non-religious** aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.

– **and –** you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

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

Section 7 Rules for ownership of durable medical equipment

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

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

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

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

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

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents

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

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

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

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

Chapter 4

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

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

This chapter provides a medical benefits chart that lists your covered services and shows how much you will pay for each covered service as a member of UnitedHealthcare® Group Medicare Advantage (HMO). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

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

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

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket amount for medical services. For calendar year 2024 this amount is $6,700.

The amounts you pay for your copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts your plan sponsor pays for your plan premium and the amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the medical benefits chart. If you reach the maximum out-of-pocket amount of $6,700, you will not have to pay any out-of-pocket costs for the rest of the plan year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

As a member of UnitedHealthcare® Group Medicare Advantage (HMO), an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called "balance billing." This protection

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

Here is how this protection works.

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

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

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

The medical benefits chart on the following pages lists the services UnitedHealthcare® Group Medicare Advantage (HMO) covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is covered in Chapter 5. The services listed in the medical benefits chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) **must** be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a Primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in

the plan's network. This is called giving you a "referral."

- 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 may need approval in advance to be covered as in-network services are marked by a double dagger (††) in the medical benefits chart.
  - Network providers agree by contract to obtain prior authorization from the plan and agree to not balance bill you.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay **more** in our plan than you would in Original Medicare. For others, you pay **less**. (If you want to know more about the coverage and costs of Original Medicare, look in your **Medicare & You 2024** handbook. View it online at medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all Preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

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

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

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

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

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

expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Providers may ask you for more than one cost share payment if you get more than one service at an appointment. For example: • Your doctor will ask for a copayment for the office visit and additional copayments for each x-ray that is performed while you are there. • Your hospital will ask for separate cost-sharing for outpatient hospital medical services and any radiological tests or Medicare Part B drugs administered while you are there. • Your pharmacist will ask for a separate copayment for each prescription he or she fills. • The specific cost-sharing that will apply depends on which services you receive. The Medical benefits chart below lists the cost-sharing that applies for each specific service.	
Abdominal aortic aneurysm screening A one-time (once per lifetime) screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

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

Services that are covered for you	What you must pay when you get these services
Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, □ a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. □ Benefit is not covered when solely provided by an independent acupuncturist. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS as required by Medicare. Acupuncture services performed by providers that do not meet CMS acupuncture provider requirements are not covered even in locations where there are no providers available that meet CMS requirements.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	$0 copayment for each one-way Medicare-covered trip. *Authorization is not required for non-emergency Medicare-covered ambulance ground transportation.* *Authorization is required for non-emergency Medicare-covered ambulance air transportation.* *Emergency ambulance does not require authorization.*

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

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

Services that are covered for you	What you must pay when you get these services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) covered once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.
Cervical and vaginal cancer screening Covered services include: □For all women: Pap tests and pelvic exams are covered once every 24 months □If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months □For asymptomatic women between the ages of 30 and 65: HPV testing once every 5 years, in conjunction with the Pap test	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: □Manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position). Manual manipulation is a treatment that uses hands-on pressure to gently move your joints and tissues. Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation, including: □Maintenance therapy. Chiropractic treatment is considered maintenance therapy when continuous ongoing care is no longer expected to provide clinical improvements and the treatment becomes supportive instead of corrective.	$5 copayment for each Medicare-covered visit.[††] You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
▯Extra charges when your chiropractor uses a manual, hand-held device to add controlled pressure during treatment. ▯X-rays, massage therapy, and acupuncture (unless the acupuncture is for the treatment of chronic low back pain).	
Routine chiropractic services Includes 12 visits per plan year. Please turn to Section 4 Routine chiropractic services of this chapter for more detailed information about this chiropractic benefit.	$5 copayment for each visit*
Colorectal cancer screening The following screening tests are covered: ▯Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. ▯Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. ▯Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. ▯Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, and colonoscopy. There is no coinsurance, copayment, or deductible for each Medicare-covered barium enema. If you have a prior history of colon cancer, or have had polyps removed during a previous colonoscopy, ongoing colonoscopies are considered diagnostic and are subject to cost-sharing as described under the outpatient surgery cost-sharing in this chart. Therefore, the screening colonoscopy

Services that are covered for you	What you must pay when you get these services
▯Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. ▯Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. ▯Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	benefit is not available for members who have signs or symptoms prior to the colonoscopy. A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the outpatient surgery cost-sharing described later in this chart.
Outpatient diagnostic colonoscopy	There is no copayment, coinsurance or deductible for each Medicare-covered diagnostic colonoscopy.††
Routine dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. Please turn to Chapter 4 Section 4 Routine dental services of this chapter for more detailed information about this preventive dental services benefit.	Individual copayments apply and discounts are available for procedures as specified later in this section.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Services that are covered for you	What you must pay when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every plan year.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include:	
□Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	$0 copayment for each Medicare-covered diabetes monitoring supply.†† For cost-sharing applicable to insulin and syringes, see Chapter 6 - What you pay for your Part D prescription drugs.
□Medicare-covered continuous glucose monitors (CGMs) and supplies are covered in accordance with Medicare Guidelines.	$0 copayment for Medicare-covered continuous glucose monitors (CGMs) and supplies.††
□For people with diabetes who have severe diabetic foot disease: One pair per plan year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of	$0 copayment for each pair of Medicare-covered therapeutic shoes.††

Services that are covered for you	What you must pay when you get these services
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. Limited to 20 visits of 30 minutes per year for a maximum of 10 hours the initial year. Follow-up training subsequent years after, limited to 4 visits of 30 minutes for a maximum of 2 hours per year.	$0 copayment for Medicare-covered benefits.
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, compression stockings for lymphedema, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at retiree.uhc.com.	$0 copayment for Medicare-covered benefits.†† Your cost-sharing for Medicare oxygen equipment coverage is $0 copayment, every time you get covered equipment or supplies.†† Your cost-sharing will not change after being enrolled for 36 months. If prior to enrolling in our plan you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in our plan is $0 copayment.††
Emergency care Emergency care refers to services that are: □Furnished by a provider qualified to furnish emergency services, and □Needed to evaluate or stabilize an emergency medical condition.	$50 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you are admitted to a hospital, you will pay cost-sharing as described in the

Services that are covered for you	What you must pay when you get these services
A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	"Inpatient hospital care" section in this benefit chart. You pay these amounts until you reach the out-of-pocket maximum.
Worldwide coverage for emergency department services. □This includes emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. □Transportation back to the United States from another country is not covered. □Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures are not covered. □Services provided by a dentist are not covered.	$50 copayment for worldwide coverage for emergency services. You do not pay this amount if admitted to the hospital within 24 hours for the same condition. If you are admitted to a hospital, you will pay cost-sharing as described in the Inpatient hospital care section in this benefit chart. Please see Chapter 7 Section 1.1 for expense reimbursement for worldwide services. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the

Services that are covered for you	What you must pay when you get these services
	cost-sharing you would pay at a network hospital. You pay these amounts until you reach the out-of-pocket maximum.
Fitness program **Renew Active® by UnitedHealthcare** Renew Active® by UnitedHealthcare is the gold standard in Medicare fitness programs for body and mind. It's available to you at no additional cost and includes: □A free gym membership at a fitness location you select from our large nationwide network. □Thousands of on-demand workout videos and live streaming fitness classes. □Social activities at local health and wellness classes and events. □An online Fitbit® Community. No Fitbit device is needed. □An online program offering content about brain health with exclusive content for Renew Active members through AARP® Staying Sharp.	Renew Active is available at no additional cost to you. Call or go online to learn more and to get your confirmation code. Log in to your plan website, go to Health & Wellness and select Renew Active or call the number on your UnitedHealthcare member ID card to obtain your code.
UnitedHealthcare Healthy at Home post-discharge program With the UnitedHealthcare Healthy at Home post-discharge program, the following benefits are available to you up to 30 days following all inpatient and skilled nursing facility discharges at no cost to you: **Home-delivered meals**	$0 copayment; benefit is available through approved vendors.

Services that are covered for you	What you must pay when you get these services
Receive 28 home-delivered meals when referred by a UnitedHealthcare Engagement Specialist. Call the number on your UnitedHealthcare member ID card to learn more or get a referral. □ Restrictions, limitations and exclusions apply, including shipping and other requirements. Meals are only available through the approved vendor □ If you have been recently discharged from the hospital or a skilled nursing facility and would like a referral, call the phone number on your UnitedHealthcare member ID card **Non-emergency transportation** Receive 12 one-way rides up to 50 miles per one-way trip to and from medically related appointments and to the pharmacy when referred by a UnitedHealthcare Engagement Specialist. Call the customer service number on your UnitedHealthcare member ID card for more information and to schedule your trips. □ New referrals are required following each discharge. If you have been recently discharged from the hospital or a skilled nursing facility and would like a referral, call the phone number on your UnitedHealthcare member ID card. □ Trips must be to or from plan-approved medically related appointments (locations); limited to ground transportation only. □ Mileage reimbursement available upon request (arrangements must be set up in advance). □ Each one-way trip must not exceed 50 miles. A trip is considered one way; a round trip is considered 2 trips. □ The benefit cannot be used for emergency related trips. Drivers do not have medical training. In case of an emergency, call 911.	

Services that are covered for you	What you must pay when you get these services
☐ One companion per trip at least 18 years of age or older. ☐ Cab/sedan services available. ☐ Standard transportation services require at least 2 business days advanced notice. ☐ Appointments can be made up to 30 days in advance. ☐ Weekend scheduling available only for urgent requests. **Non-Medical personal care** Receive 6 hours of non-medical personal care each year provided through a professional caregiver to perform tasks such as companionship, meal prep, medication reminders and more. Call the customer service number on your UnitedHealthcare member ID card for more information and to request and schedule care. ☐ No referral required. ☐ Unused hours do not roll over. ☐ Caregiver hours must be scheduled in 2-hour increments. ☐ You will typically be paired with a caregiver within 5 business days. ☐ Some restrictions and limitations apply. You are not required to use all 3 services. New referrals for meals and transportation benefits are required after each discharge. Unused benefits do not roll over.	
Hearing services 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.	$5 copayment for each Medicare-covered exam.[††] You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Routine hearing services Please turn to Section 4 Routine Hearing Services of this chapter for more detailed information about this benefit.	**Hearing exam** $0 copayment for 1 exam per plan year. **Hearing aids** The plan pays up to a $500 allowance for hearing aids (combined for both ears) every 3 years.* To access your hearing aid benefits, you must contact UnitedHealthcare Hearing at 1-866-445-2071, TTY 711.
Hepatitis C screening For people that meet one of the following conditions: □High risk because of current or past history of illicit injection drug use □Had a blood transfusion before 1992 □Born between 1945 – 1965 Screening is covered annually only for high risk people with continued illicit drug use since the prior negative screening test. Screening is covered once in a lifetime for people that were born between 1945 and 1965, who are not considered high risk.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered Hepatitis C screening.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: □One screening exam every 12 months For women who are pregnant, we cover:	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.

Services that are covered for you	What you must pay when you get these services
☐Up to three screening exams during a pregnancy	
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: ☐Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) ☐Physical therapy, occupational therapy, and speech therapy ☐Medical and social services ☐Medical equipment and supplies	$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met.†† Other copayments or coinsurance may apply (Please see Durable medical equipment and related supplies for applicable copayments or coinsurance).
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: ☐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	You will pay the cost-sharing that applies to primary care services, specialist physician services, or home health (as described under “Physician/ practitioner services, including doctor’s office visits” or “Home health agency care”) depending on where you received administration or monitoring services.†† See "Durable medical equipment" earlier in this chart for any applicable cost-sharing

Services that are covered for you	What you must pay when you get these services
□Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	for equipment and supplies related to home infusion therapy. †† See "Medicare Part B prescription drugs" later in this chart for any applicable cost-sharing for drugs related to home infusion therapy.††
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: □Drugs for symptom control and pain relief □Short-term respite care □Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. **For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not UnitedHealthcare® Group Medicare Advantage (HMO). **Note:** If you are not entitled to Medicare Part A coverage, hospice services are not covered by the plan or by Medicare. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.

Services that are covered for you	What you must pay when you get these services
will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost-sharing. **For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, you pay your plan cost-sharing amount for these services. Please refer to this Benefits Chart. □ If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services □ If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by UnitedHealthcare® Group Medicare Advantage (HMO) but are not covered by Medicare Part A or B: UnitedHealthcare® Group Medicare Advantage (HMO) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost-sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost-sharing. 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**). Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	

Services that are covered for you	What you must pay when you get these services
Immunizations Covered Medicare Part B services include: □Pneumonia vaccine □Flu vaccine, one each flu season in the fall and winter, with additional flu vaccine shots if medically necessary □Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B □COVID-19 vaccine □Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit, such as shingles or tetanus booster shots. See Chapter 6 for more information about coverage and applicable cost-sharing.	There is no coinsurance, copayment, or deductible for the pneumonia, flu, Hepatitis B, or COVID-19 vaccines. There is no coinsurance, copayment, or deductible for all other Medicare-covered immunizations.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include, but are not limited to: □Semi-private room (or a private room if medically necessary) □Meals including special diets □Regular nursing services □Costs of special care units (such as intensive care or coronary care units) □Drugs and medications □Lab tests	$0 copayment for each Medicare-covered hospital stay each time you are admitted.†† If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions of important words.) For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the

Services that are covered for you	What you must pay when you get these services
□X-rays and other radiology services □Necessary surgical and medical supplies □Use of appliances, such as wheelchairs □Operating and recovery room costs □Physical, occupational, and speech language therapy □Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. The plan has a network of facilities that perform organ transplants. The plan's hospital network for organ transplant services is different than the network shown in the 'Hospitals' section of your provider directory. Some hospitals in the plan's network for other medical services are not in the plan's network for transplant services. For information on network facilities for transplant services, please call UnitedHealthcare® Group Medicare Advantage (HMO) Customer Service at 1-800-457-8506 TTY 711. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If UnitedHealthcare® Group Medicare Advantage (HMO) provides transplant services at a location outside of the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. While you are receiving care at the distant location, we will also reimburse transportation costs to and from the hospital or doctor's office for evaluations, transplant	hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

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

Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital Covered services include: □Mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. □Inpatient substance abuse services	$0 copayment per Medicare-covered admission.†† Medicare hospital benefit periods are used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in the chapter titled Definitions of important words.) However, the cost-sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times within a benefit period.
Inpatient stay: covered services received in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:	When your stay is no longer covered, these services will be covered as described in the following sections:
□Physician services	Please refer below to Physician/ practitioner services, including doctor's office visits.
□Diagnostic tests (like lab tests)	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.

Services that are covered for you	What you must pay when you get these services
☐X-ray, radium, and isotope therapy including technician materials and services	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
☐Surgical dressings ☐Splints, casts and other devices used to reduce fractures and dislocations	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
☐Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	Please refer below to Prosthetic devices and related supplies.
☐Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	Please refer below to Prosthetic devices and related supplies.
☐Physical therapy, speech language therapy, and occupational therapy	Please refer below to Outpatient rehabilitation services.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	What you must pay when you get these services
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 plan year.	
Medicare diabetes prevention program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B Prescription Drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: □Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services □Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) □Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan □Clotting factors you give yourself by injection if you have hemophilia □Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant □Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug	$0 copayment for each Medicare-covered Part B drug and non-chemotherapy drugs to treat cancer.[††] Additionally, for the administration of that drug, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/ practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you received drug administration or infusion services.

Services that are covered for you	What you must pay when you get these services
☐Antigens (for allergy shots) ☐Certain oral anti-cancer drugs and anti-nausea drugs ☐Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) ☐Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases ☐Chemotherapy Drugs, and the administration of chemotherapy drugs You or your doctor may need to provide more information about how a Medicare Part B prescription drug is used in order to determine coverage. There may be effective, lower-cost drugs that treat the same medical condition. If you are prescribed a new Part B medication or have not recently filled the medication under Part B, you may be required to try one or more of these other drugs before the plan will cover your drug. If you have already tried other drugs or your doctor thinks they are not right for you, you or your doctor can ask the plan to cover the Part B drug. (For more information, see Chapter 9, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).) Please contact Customer Service for more information. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	$0 copayment for each Medicare-covered chemotherapy drug to treat cancer and the administration of that drug.††
24/7 Nurse Support	Receive access to nurse consultations and additional clinical resources at no additional cost.

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

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

Services that are covered for you	What you must pay when you get these services
□Other outpatient diagnostic tests - non-radiological diagnostic services	$0 copayment for Medicare-covered non-radiological diagnostic services.†† Examples include, but are not limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests.
□Other outpatient diagnostic tests - radiological diagnostic services, not including x-rays.	$0 copayment for Medicare-covered radiological diagnostic services, not including X-rays.†† The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).

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

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

Services that are covered for you	What you must pay when you get these services
□Outpatient infusion therapy For the drug that is infused, you will pay the cost-sharing as described in "Medicare Part B prescription drugs" in this benefit chart. In addition, for the administration of infusion therapy drugs, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under “Physician/ practitioner services, including doctor’s office visits” or “Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers” in this benefit chart) depending on where you received drug administration or infusion services.	services provided at hospital outpatient facilities and ambulatory surgical centers. Please refer to Medicare Part B prescription drugs and Physician/practitioner services, including doctor’s office visits or Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” This is called an “outpatient observation” stay. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Outpatient injectable medications (Self-administered outpatient injectable medications not covered under Part B of Original Medicare)	$0 copayment for each self-administered outpatient injectable medication.

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. Please refer to virtual behavioral visits section in this chart for more information.	$5 copayment for each Medicare-covered **individual** therapy session.†† $5 copayment for each Medicare-covered **group** therapy session.†† You pay these amounts until you reach the out-of-pocket maximum.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, physician offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$5 copayment for each Medicare-covered physical therapy and speech-language therapy visit.†† You pay these amounts until you reach the out-of-pocket maximum. $5 copayment for each Medicare-covered occupational therapy visit.†† You pay these amounts until you reach the out-of-pocket maximum. $5 copayment for each Medicare-covered comprehensive outpatient rehabilitation facility (CORF) visit.†† You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Outpatient substance abuse services Outpatient treatment and counseling for substance abuse.	$5 copayment for each Medicare-covered **individual** therapy session.†† $5 copayment for each Medicare-covered **group** therapy session.†† You pay these amounts until you reach the out-of-pocket maximum.
Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers **Note**: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "Outpatient Observation" stay. If you are not sure if you are an outpatient, you should ask your doctor or the hospital staff. If you receive any services or items other than surgery, including but not limited to diagnostic tests, therapeutic services, prosthetics, orthotics, supplies or Part B drugs, there may be additional cost-sharing for those services or items. Please refer to the appropriate section in this chart for the additional service or item you received for the specific cost-sharing required. See "Colorectal cancer screening" earlier in this chart for screening and diagnostic colonoscopy benefit information.	$0 copayment for Medicare-covered surgery or other services at an outpatient hospital or ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges.†† Outpatient surgical services that can be delivered in an available ambulatory surgery center must be delivered in an ambulatory surgery center unless a hospital outpatient department is medically necessary. $0 copayment for Medicare-covered observation at an outpatient hospital or ambulatory surgical center.††

Services that are covered for you	What you must pay when you get these services
Partial hospitalization services and Intensive outpatient services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	$50 copayment each day for Medicare-covered benefits.[††] You pay these amounts until you reach the out-of-pocket maximum.
Personal emergency response system (PERS) Lifeline A personal emergency response system (PERS) benefit is available to you through the provider, Lifeline. With a PERS, help is only a button press away. A PERS can quickly connect you to the help you need, 24 hours a day in any situation. It's a lightweight, water-resistant button that can be worn on your wrist or as a pendant. Depending on the model you choose, it may even automatically detect falls. You must have a working landline or live in an area that has cellular coverage. The cellular device works nationwide with the AT&T and Verizon wireless networks, but does not require you to have AT&T or Verizon. For additional information or to order your device, please call 1-855-595-8485 TTY 711 or visit lifeline.com/uhcgroup.	$0 copayment; Benefit is available through provider Lifeline.

Services that are covered for you	What you must pay when you get these services
Provided by: Lifeline	
Physician/practitioner services, including doctor's office visits Covered services include:	
□Medically-necessary medical or surgical services furnished in a physician's office.	$5 copayment for services from a primary care provider or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a primary care provider's office (as allowed by Medicare). You pay these amounts until you reach the out-of-pocket maximum.
□Medically-necessary medical or surgical services furnished in a certified ambulatory surgical center or hospital outpatient department.	See "Outpatient surgery" earlier in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.
□Consultation, diagnosis, and treatment by a specialist.	$5 copayment for services from a specialist or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a specialist's office (as allowed by Medicare).[††]

Services that are covered for you	What you must pay when you get these services
	You pay these amounts until you reach the out-of-pocket maximum.
□Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment.	$5 copayment for each Medicare-covered exam.[††] You pay these amounts until you reach the out-of-pocket maximum.
□Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare. □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 to diagnose, evaluate, or treat symptoms of a stroke regardless of their 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 □Medicare-covered remote patient monitoring services □Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: □ You're not a new patient and □ The check-in isn't related to an office visit in the past 7 days and □ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment.	$0 copayment for each Medicare-covered visit.[††]

Services that are covered for you	What you must pay when you get these services
□Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: □ You're not a new patient and □ The evaluation isn't related to an office visit in the past 7 days and □ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment.	
□Consultation your doctor has with other doctors by phone, internet, or electronic health record.	$0 copayment for each Medicare-covered consultation.
□Second opinion by another network provider prior to surgery.	You will pay the cost-sharing that applies to specialist services (as described under “Physician/practitioner services, including doctor’s office visits” above).††
□Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, oral exams before a kidney transplant or services that would be covered when provided by a physician). Dental services provided by a dentist in connection with care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not Medicare-covered benefits and not covered under this benefit.	$5 copayment for each Medicare-covered visit.†† You pay these amounts until you reach the out-of-pocket maximum.
□Monitoring services in a physician’s office or outpatient hospital setting if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin	You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital

Services that are covered for you	What you must pay when you get these services
(these services may also be referred to as 'Coumadin Clinic' services).	services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you receive services.††
Medically-necessary medical or surgical services that are covered benefits and are furnished by a physician in your home or a nursing home in which you reside.	You will pay the cost-sharing that applies to primary care provider services or specialist physician services (as applied in an office setting, described above in this section of the benefit chart) depending on the type of physician that provides the services.††
	$0 copayment for certain primary care provider, nurse practitioner, physician's assistant, or other non-physician health care professional services furnished in the home by designated providers§
Certain telehealth services, including:	
Virtual doctor visits	See "Virtual doctor visits" in this chart for any applicable copayments or coinsurance.

Services that are covered for you	What you must pay when you get these services
□ Virtual behavioral visits	See "Virtual behavioral visits" in this chart for any applicable copayments or coinsurance.
Podiatry services Covered services include: □Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). □Routine foot care for members with certain medical conditions affecting the lower limbs.	$5 copayment for each Medicare-covered visit in an office or home setting.†† For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers. You pay these amounts until you reach the out-of-pocket maximum.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: □Digital rectal exam □Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test. Diagnostic PSA exams are subject to cost-sharing as described under Outpatient diagnostic tests and therapeutic services and supplies in this chart.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic	$0 copayment for each Medicare-covered prosthetic device, including replacement or repairs of such devices, and related supplies.†† $0 copayment for each Medicare-covered orthotic

Services that are covered for you	What you must pay when you get these services
devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision services" later in this section for more detail.	device, including replacement or repairs of such devices, and related supplies.††
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Medicare covers up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of pulmonary rehabilitation services.	$5 copayment for each Medicare-covered pulmonary rehabilitative visit.†† You pay these amounts until you reach the out-of-pocket maximum.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening per year for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. **For LDCT lung cancer screenings after the initial LDCT screening:** the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include:	

Services that are covered for you	What you must pay when you get these services
□Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.	$0 copayment for Medicare-covered benefits.
□Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	$5 copayment for Medicare-covered benefits.†† You pay these amounts until you reach the out-of-pocket maximum.
□Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	$0 copayment for Medicare-covered benefits.
□Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)	These services will be covered as described in the following sections: Please refer to Inpatient hospital care.
□Home dialysis equipment and supplies	Please refer to Durable medical equipment and related supplies.
□Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	Please refer to Home health agency care.
Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.”	

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this document. Skilled nursing facilities are sometimes called "SNFs.") Covered services include, but are not limited to: □Semiprivate room (or a private room if medically necessary) □Meals, including special diets □Skilled nursing services □Physical therapy, occupational therapy, and speech language therapy □Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) □Blood - including storage and administration. Coverage begins with the first pint of blood that you need. □Medical and surgical supplies ordinarily provided by SNFs □Laboratory tests ordinarily provided by SNFs □X-rays and other radiology services ordinarily provided by SNFs □Use of appliances such as wheelchairs ordinarily provided by SNFs □Physician/practitioner services A 3-day prior hospital stay is not required. Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. □A nursing home or continuing care retirement community where you were living right before you went	$0 copayment each day for Medicare-covered SNF care, up to 100 days.†† You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Services that are covered for you	What you must pay when you get these services
to the hospital (as long as it provides skilled nursing facility care). □A SNF where your spouse or domestic partner is living at the time you leave the hospital.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, we cover two counseling quit attempts within a 12-month period as a preventive service. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and have a referral from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: □Consist of sessions lasting 30-60 minutes, comprising of a therapeutic exercise-training program for PAD in patients with claudication □Be conducted in a hospital outpatient setting or a physician's office □Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD □Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$5 copayment for each Medicare-covered supervised exercise therapy (SET) visit.†† You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Worldwide coverage for 'urgently needed services' when medical services are needed right away because of an illness, injury, or condition that you did not expect or anticipate, and you can't wait until you are back in our plan's service area to obtain services. Services provided by a dentist are not covered.	$5 copayment for each visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Virtual behavioral visits UnitedHealthcare's virtual behavioral visits lets you choose to see and speak to a mental health professional using your computer or a mobile device, like a tablet or smart phone. This service can be used for initial evaluation, medication management and ongoing counseling. Providers can't prescribe medications in all states. Virtual Behavioral Health also includes cognitive behavioral health therapy. Cognitive behavioral health therapy is a type of therapy that works on your thoughts and beliefs and how they affect your actions.	$5 copayment using providers that have the ability and are qualified to offer virtual behavioral visits. You pay these amounts until you reach the out-of-pocket maximum.
Virtual doctor visits UnitedHealthcare's virtual doctor visits lets you choose to see and speak to doctors using your computer or a mobile device, like a tablet or smart phone. These doctors are providers that have the ability to offer virtual doctor visits. During a virtual visit, you can ask questions, get a diagnosis and the doctor may be able to prescribe medication that, if appropriate, can be sent to your pharmacy. Doctors can't prescribe medications in all states. You can find a list of participating virtual doctors online at retiree.uhc.com.	$0 copayment using providers that have the ability and are qualified to offer virtual medical visits.
Vision services Covered services include:	
□Outpatient physician services provided by an ophthalmologist or optometrist for the diagnosis and treatment of diseases and injuries of the eye, including diagnosis or treatment for age-related macular degeneration or cataracts. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.	$5 copayment for each Medicare-covered exam.[††] You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older.	$0 copayment for Medicare-covered glaucoma screening.
For people with diabetes or signs and symptoms of eye disease, eye exams to evaluate for eye disease are covered per Medicare guidelines. Annual examinations by an ophthalmologist or optometrist are recommended for asymptomatic diabetics.	$5 copayment for each Medicare-covered diabetic eye exam.†† You pay these amounts until you reach the out-of-pocket maximum.
One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (additional pairs of eyeglasses or contacts are not covered by Medicare). If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery. Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any upgrades are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating).	$0 copayment for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.
Routine vision services Please turn to Section 4 Routine vision services of this chapter for more detailed information about this benefit.	**Eye Exam** $5 copayment for 1 exam every 12 months.*

Services that are covered for you	What you must pay when you get these services
	Eyewear Plan pays up to $130 for 1 frame with standard lenses covered in full, or up to $175 for contact lenses instead of eyeglasses, every 24 months.*
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this medical benefits chart. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. There is no copayment or coinsurance for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" preventive visit. Please refer to outpatient diagnostic tests and therapeutic services and supplies for other EKG's.

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

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

§ Call Customer Service at the number on your UnitedHealthcare member ID card for more details.

Section 3 What Medical services are not covered by the plan?

Section 3.1 Medical services we do not cover (exclusions)

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

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

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

The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Full-time nursing care in your home.	Not covered under any condition	
Custodial care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	Not covered under any condition	
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	Not covered under any condition	
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition	
Cosmetic surgery or procedures.		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Chiropractic services (Medicare-covered)		Manual manipulation of the spine to correct a subluxation is covered. Excluded from Medicare coverage is any service other than manual manipulation of the spine for the treatment of subluxation.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine foot care.		Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Home-delivered meals.	Not covered under any condition	
Orthopedic shoes or supportive devices for the feet.		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease. (As specifically described as a covered service in the medical benefits chart in this chapter.)
Outpatient prescription drugs.		Some coverage provided according to Medicare guidelines. (As specifically described in the medical benefits chart in this chapter or as outlined in Chapter 6.)
Elective hysterectomy, tubal ligation, or vasectomy, if the primary indication for these procedures is sterilization. Reversal of sterilization procedures, penile vacuum erection devices, or non-prescription contraceptive supplies.	Not covered under any condition	
Acupuncture (Medicare-covered).		Available for people with chronic low back pain under certain circumstances. (As specifically described in the medical benefits chart in this chapter.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Naturopath services (uses natural or alternative treatments).	Not covered under any condition	
All services, procedures, treatments, medications and supplies related to workers' compensation claims.	Not covered under any condition	
Physical examinations for the purpose of maintaining or obtaining employment, licenses, insurance, court hearings, travel, dietary counseling, weight reduction programs or for premarital and pre-adoption purposes and/or other non-preventive reasons.	Not covered under any condition	
Abortion.		Cases resulting in pregnancies from rape or incest or that endanger the life of the mother.
Health services for treatment of military service related disabilities provided by the Military Health Services System (including CHAMPUS or TRICARE) under which the federal government agrees to pay for the services and supplies.	Not covered under any condition	
Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport)		Services are only covered when the ambulance pick-up address is located in rural New York and applicable conditions are met. Members are responsible for all paramedic intercept service costs that occur outside of rural New York.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including but not limited to home and car remodeling or modification, and exercise equipment.	Not covered under any condition	
Immunizations for foreign travel purposes.	Not covered under any condition	
The following services and items are excluded from coverage under the "Optum Designated Transplant Network" transplant program:	Unauthorized or not prior authorized organ procurement and transplant related services. Non-Medicare-covered organ transplants. Transplant services, including donor costs, when the transplant recipient is not a member. Artificial or non-human organs. Transportation of any potential donor for typing and matching. Services for which government funding or	Transplants performed in a non-Optum Designated Transplant Network program, unless specifically authorized by the Optum Transplant Medical Director. Transportation services for any day a member is not receiving medically necessary transplant services, except as covered in accordance with Medicare guidelines. Food and housing costs for any day a member is not receiving medically necessary transplant services, except as covered in accordance with Medicare guidelines. Storage costs for any organ or bone marrow, unless authorized

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
	other insurance coverage is available.	by the Optum Transplant Medical Director. Bone marrow transplants or stem cell transplantation, except as a treatment for an appropriate diagnosis as specifically stated in the Medicare coverage guidelines or in the Evidence of Coverage.
Any non-emergency care received outside of the United States and the U.S. Territories.	Not covered under any condition	
For transplants: items not covered include, but are not limited to the below. For transportation: □Vehicle rental, purchase, or maintenance/repairs □Auto clubs (roadside assistance) □Gas □Travel by air or ground ambulance (may be covered under your medical benefit). □Air or ground travel not related to medical appointments □Parking fees incurred other than at lodging or hospital For lodging: □Deposits □Utilities (if billed separate from the rent payment) □Phone calls, newspapers, movie rentals and gift cards	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
□Expenses for lodging when staying with a relative or friend □Meals		
Personal emergency response system (PERS)		As specifically described as a covered service in the medical benefits chart in this chapter.
UnitedHealthcare Healthy at Home post-discharge program		As specifically described as a covered service in the medical benefits chart in this chapter.
Fitness program Renew Active® by UnitedHealthcare.		As specifically described as a covered service in the medical benefits chart in this chapter.
Self-administered drugs in an outpatient hospital		Covered only under specific conditions.

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

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

Section 4 Other additional benefits (not covered under Original Medicare)

Introduction

Your health and well-being are important to us, which is why we've developed the additional benefit(s) detailed in this section:

- □Routine dental services
- □Routine hearing services

- Routine vision services
- Routine chiropractic services

The benefit(s) described on the following pages are designed to help you stay healthy and provide well-rounded health coverage. Please read this section carefully, and reference it later if need be, to help you know what services are covered under your plan. If you ever have questions about what is covered, how to make a claim or about any other issue, please call Customer Service (phone numbers for Customer Service are on the cover of this booklet). We are always happy to provide answers to any questions you may have. We're here to serve you.

The information in this section describes the following benefits:

- Dental benefits
- Routine eye exam and routine eyewear
- Routine chiropractic care

Refer to the Routine hearing services benefit section below for more details on your routine hearing benefit.

These are covered health services when you follow the coverage rules in the Evidence of Coverage. These services are in addition to Medicare-covered benefits outlined in the Evidence of Coverage. The provisions of this section are incorporated into and made a part of your Evidence of Coverage. Copayments or coinsurance for these covered health services do not apply toward the annual out-of-pocket maximum (if applicable to your plan) described earlier in this chapter.

Further details on the benefits available as part of your additional benefit(s) (if applicable) are detailed in the section titled: **Covered services**.

Submit a claim or request reimbursement
When you obtain services, the service provider normally submits a claim on your behalf. If the service provider is unwilling to do so, you can ask us for reimbursement. Refer to Chapter 7 Section 2 *How to ask us to pay you back or to pay a bill you have received*.

Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered.

Limitation of liability

We will not reduce or deny a claim for failure to furnish such proof within the time required, provided a claim is furnished as soon as reasonably possible. Except in the absence of legal capacity, we will not accept a claim more than one (1) year from the date of service.

Access your benefits

Each additional benefit detailed here has a directory of network service providers that furnish in-network covered health services. To start using your additional benefit in-network:

Select a network provider* from the directory, or call Customer Service for help in determining a network provider (phone numbers for Customer Service are on the back cover of this booklet).

Routine dental services

Covered services
The dental benefits available through your plan include preventive, diagnostic, minor and major dental services from a network dentist.

- You pay $0 for each periodic oral examination once every 6 months.
- You pay $5 for each routine cleaning once every 6 months.
- You pay $0 for a complete X-ray series once every 2 years prescribed by your assigned network dentist.
- Please refer to the dental fee schedule for the list of covered dental care services and cost sharing amounts.
- Covered dental services at network dentist offices is subject to the limitations and exclusions described later in this section.
- All dental care services covered by this plan must be coordinated by your network dentist.
- Dental procedures not listed are not covered.

How to choose an assigned network dentist
We will send you information about our current network of dentists. You must select a network dentist from the list who will be responsible for coordinating all of your dental care. If the dental office you selected is not available, or you don't choose an office, we will assign one to you. If you would like to select another network dental office, you may contact Customer Service (phone numbers for Customer Service are on the back cover of this booklet). We review transfer requests on a case-by-case basis. If we receive your request to transfer to another network dentist by the 20th of the month, your transfer will be effective on the first day of the following month. For example: If your request to transfer is received on June 17, your transfer will be effective on July 1. Additionally, if your request to transfer is received by June 21, your transfer will be effective on August 1.

To ensure continuity of care, all treatments started at your selected network dentist should be completed before you request a change to another network dental office, unless a quality-of-care issue is identified. If you choose to change network dental offices without completing treatment, you may be responsible for all billed charges by your new network dentist.

A network dentist is required to copy and deliver your complete patient file upon your request. Your dentist may charge you a reasonable fee for the copying and delivery of your records.

Making an appointment
Once you have selected a network dentist, you can make an appointment by directly calling that dental office. All dental care services covered by this plan must be coordinated by your network dentist.

Emergency care
Your selected network dentist will be available for emergency care 24 hours a day, 7 days a week. If you need emergency care, you must contact your network dentist. If you are unable to reach them, you must call our Customer Service department for instructions.

If you have an emergency after normal business hours and are unable to reach your selected network dentist, you can see any licensed dentist for emergency dental care services. Within 2 business days, you should let Customer Service know you received emergency dental services and they'll give you instructions on how to submit your claim.

Organization determination, appeal and grievance procedures
If you wish to file an appeal or grievance, please see the details on how to make an appeal in Chapter 9 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

Limitations and exclusions:
The following items and services are limited and excluded from your additional dental benefit:

- Government treatment for any services provided in a local, state or federal government facility or agency except when payment under the plan is expressly required by federal or state law.
- Any treatment or services caused by or arising out of the course of employment or covered under any public liability insurance, including, but not limited to, Worker's Compensation programs.
- Services performed by an out-of-network dentist if your plan does not have out-of-network coverage.
- Dental services that are not necessary.
- Hospitalization or other facility charges.
- Any dental procedure performed solely for cosmetic and/or aesthetic reasons.
- Any dental procedure not directly associated with a dental disease.
- Any procedure not performed in a dental setting.
- Reconstructive surgery of any type.
- Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on dental therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
- Any implant procedures performed which are not listed as covered implant procedures in the dental fee schedule.
- Drugs/medications, obtainable with or without a prescription, unless they are dispensed and used in the dental office during your visit.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.
- Replacement of complete dentures, fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the network dentist. If replacement is due to non-compliance, you are responsible for the cost of replacement.

- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
- Service for injuries or conditions covered by workmen's compensation or employer liability laws, and services that are provided without cost to you by any municipality, county, or other political subdivision. This exclusion does NOT apply to any services covered by Medicaid or Medicare.
- Services and supplies not specifically provided in the plan including:
  - Outpatient disposable or consumable dental supplies.
  - Personal supplies or tools, such as waterpiks or water jet devices, sonic devices, dental floss, toothbrushes, antibiotic rinses and toothpaste.
- Expenses for dental procedures begun prior to your eligibility with the plan.
- Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown, or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Procedures related to the reconstruction of your correct vertical dimension of occlusion (VDO).
- Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- Dental services rendered (including otherwise covered dental services) after the date on which individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date on which individual coverage under the policy terminates.
- Services rendered by a provider with the same legal residence as you or who is a member of your family, including a spouse, brother, sister, parent or child.
- Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- Foreign services are not covered, unless required as an emergency.
- Dental care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- Any request for specialist services or treatment which can be routinely provided by the network dentist. Or treatment by a specialist without referral from the network dentist and our approval.
- Cephalometric X-rays.
- Consultations for non-covered services.
- A service started but not completed prior to your eligibility to receive benefits under the plan.

Inlays, onlays and fixed bridges are considered started when the tooth or teeth are prepared. Root canal treatment is considered started when the pulp chamber is opened. Orthodontics are considered started at the time of initial banding. Dentures are considered started when the impressions are taken.

- A service started (as defined above) by an out-of-network dentist. This does not apply to covered emergency dental care services.
- Procedures performed to facilitate non-covered services, including but not limited to a root canal therapy to facilitate either hemisection or root amputation, and osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Relative analgesia (N2O2- nitrous oxide).
- Major restorative services relating to teeth that are not periodontally sound or that have a questionable prognosis of less than 5 years.
- Any services not listed above may not be covered.

General limitations of benefits
All dental procedures and services are limited as specifically described below:

1. Periodic oral evaluation	Limited to 1 time per 6 months
2. Complete series or panorex radiographs	Limited to 1 time in any 2-year period
3. Bitewing radiographs	Limited to 1 series of 4 films in any 6-month period
4. Dental prophylaxis	Limited to 1 time per 6 months
5. Fluoride treatments	Limited to 1 time per calendar year
6. Crowns	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
7. Post and cores	Covered only for teeth that have had root canal therapy.
8. Scaling and root planing	Limited to 4 quadrants per calendar year.
9. Periodontal maintenance	Limited to once every 6 months, following active therapy, exclusive of gross debridement
10. Replacement of complete dentures fixed or removable partial dentures, crowns, inlays or onlays and implants, implant crowns, implant prothesis	Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays, onlays, and implant crowns, implant prostheses previously submitted for payment under the plan is limited to 1 time per tooth per 5 years from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable orthodontic appliances.

11. Removable prosthetics/fixed prosthetics/crowns, inlays and onlays (major restorative services)	Replacement of complete dentures, and fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of non-compliance, you are responsible for the cost of replacement.
12. Crowns retainers/abutments	Limited to 1 time per tooth per 5 years.
13. Temporary crowns restorations	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14. Inlays/onlays retainers/abutments	Limited to 1 time per tooth per 5 years.
15. Inlays/onlays restorations	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
16. Stainless steel crowns	Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown -primary tooth, are limited to primary anterior teeth.
17. Adjustments to full dentures, partial dentures, bridges or crowns	Limited to repairs or adjustments performed more than 6 months after the initial insertion.
18. Intravenous sedation or general anesthesia	Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).
19. Adjunctive pre-diagnostic test	That aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, must be 30 years or older.

20. All specialty referral services must be	• Pre-authorized by us; and • Coordinated by your network dentist. If you get specialist care without prior referral by your network dentist and approval by us, you will be responsible for all charges. In order for specialty services to be covered by this plan, the following referral process must be followed: • Your network dentist must coordinate all dental services. • When you need care from a network specialist dentist, your network dentist must contact us and request authorization. • If your network dentist's request for specialist referral is denied, you and your dentist will be notified of the reason for the denial. If the service in question is a covered service, and no limitations or exclusions apply, the network dentist may be asked to perform the service. • When you receive authorized specialty services, you must pay all applicable copayments associated with the services provided. When we authorize specialty dental care, you will be referred to a network specialist dentist for treatment. Our network includes specialist dentists in endodontics, oral surgery, pediatric dentistry, orthodontics and periodontics, located in your service area. If there is no network specialist dentist in your service area, we will refer you to a non-participating specialist of our choice. Except for emergency dental services, we will not cover dental care from a specialist who was not preauthorized by us. • Your financial responsibility is limited to applicable copayments listed in the dental fee schedule.
21. Crowns, fixed bridges, and implants	The maximum benefit within a 12-month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for you within a 12-month period, the dentist's fee for any additional crowns within that period will not be limited to the listed copayment, but instead can reflect the dentist's billed charges.
22. Cone beam	Limited to 1 per 60 consecutive months.

Dental fee schedule

Procedure Code	Procedure Description	Member Copayment
Diagnostic Services		
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem-focused, by report	$0
D0170	Re-evaluation, limited, problem focused	$0
D0171	Re-evaluation - post-operative office visit	$5
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0190	Screening of a patient	$5
D0191	Assessment of a patient	$5
D0210	Intraoral - comprehensive series of radiographic images	$0
D0220	Intraoral - periapical first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source and detector	$0
D0251	Extra-oral posterior dental radiographic image	$0
D0270	Bitewing - single radiographic image	$0
D0272	Bitewings - two radiographic images	$0
D0273	Bitewings - three radiographic images	$0
D0274	Bitewings - four radiographic images	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0330	Panoramic radiographic image	$5
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	$50
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	$55
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	$55
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	$65
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	$75
D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	$0
D0373	Intraoral tomosynthesis - bitewing radiographic image	$0
D0374	Intraoral tomosynthesis - periapical radiographic image	$0

D0387	Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only	$0
D0388	Intraoral tomosynthesis - bitewing radiographic image - image capture only	$0
D0389	Intraoral tomosynthesis - periapical radiographic image - image capture only	$0
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image	$5
D0414	Lab processing of microbial specimen to include culture and sensitivity studies	$0
D0415	Collection of microorganisms for culture and sensitivity	$0
D0416	Viral culture	$10
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	$10
D0418	Analysis of saliva sample	$10
D0422	Collection and preparation of genetic sample material for laboratory analysis and report	$0
D0423	Genetic test for susceptibility to diseases-specimen analysis	$0
D0425	Caries susceptibility tests	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesion	$20
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$12
D0472	Accession of tissue, gross examination, prep and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, prep and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic exam, includes assessment of margins, prep and transmission of report	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	$0
D0701	Panoramic radiographic image - image capture only	$5
D0702	2-D cephalometric radiographic image - image capture only	$5
D0705	Extra-oral posterior dental radiographic image - image capture only	$0
D0706	Intraoral - occlusal radiographic image - image capture only	$0
D0707	Intraoral - periapical radiographic image - image capture only	$0

D0708	Intraoral - bitewing radiographic image - image capture only	$0
D0709	Intraoral - comprehensive series of radiographic images - image capture only	$0
D0999	Unspecified diagnostic procedure, by report	$0
Preventive Services		
D1110	Prophylaxis - adult	$5
D1206	Topical application of fluoride varnish	$5
D1208	Topical application of fluoride - excluding varnish	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1355	Caries preventive medicament application - per tooth	$0
D1999	Unspecified preventive procedure, by report	$0
Restorative Services		
D2140	Amalgam - one surface, primary or permanent	$15
D2150	Amalgam - two surfaces, primary or permanent	$20
D2160	Amalgam - three surfaces, primary or permanent	$25
D2161	Amalgam - four or more surfaces, primary or permanent	$30
D2330	Resin-based composite - one surface, anterior	$20
D2331	Resin-based composite - two surfaces, anterior	$25
D2332	Resin-based composite - three surfaces, anterior	$30
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$40
D2390	Resin-based composite crown, anterior	$70
D2391	Resin-based composite - one surface, posterior	$65
D2392	Resin-based composite - two surfaces, posterior	$85
D2393	Resin-based composite - three surfaces, posterior	$105
D2394	Resin-based composite - four or more surfaces, posterior	$120
D2510	Inlay - metallic - one surface	$200
D2520	Inlay - metallic - two surfaces	$200
D2530	Inlay - metallic - three or more surfaces	$200
D2542	Onlay metallic, two surfaces	$250
D2543	Onlay-metallic-three surfaces	$250
D2544	Onlay-metallic-four or more surfaces	$250
D2610	Inlay - porcelain/ceramic - one surface	$305
D2620	Inlay - porcelain/ceramic - two surfaces	$305
D2630	Inlay - porcelain/ceramic - three or more surfaces	$305
D2642	Onlay - porcelain/ceramic - two surfaces	$305
D2643	Onlay - porcelain/ceramic - three surfaces	$305
D2644	Onlay - porcelain/ceramic - four or more surfaces	$305
D2650	Inlay - composite/resin - one surface	$305
D2651	Inlay - composite/resin - two surfaces	$305

D2652	Inlay - composite/resin - three or more surfaces	$305
D2662	Onlay - composite/resin - two surfaces	$305
D2663	Onlay - composite/resin - three surfaces	$305
D2664	Onlay - composite/resin - four or more surfaces	$305
D2710	Crown,resin-based composite (indirect)	$180
D2712	Crown - 3/4 resin-based composite (indirect)	$180
D2720	Crown - resin with high noble metal	$250
D2721	Crown - resin with predominantly base metal	$250
D2722	Crown - resin with noble metal	$250
D2740	Crown - porcelain/ceramic	$350
D2750	Crown - porcelain fused to high noble metal	$305
D2751	Crown - porcelain fused to predominantly base metal	$305
D2752	Crown - porcelain fused to noble metal	$305
D2753	Crown - porcelain fused to titanium and titanium alloys	$305
D2780	Crown, 3/4 cast high noble metal	$305
D2781	Crown, 3/4 cast predominantly base metal	$305
D2782	Crown, 3/4 cast noble metal	$305
D2783	Crown, 3/4 porcelain/ceramic	$305
D2790	Crown - full cast high noble metal	$305
D2791	Crown - full cast predominantly base metal	$305
D2792	Crown - full cast noble metal	$305
D2794	Crown - titanium and titanium alloys	$305
D2910	Recement or re-bond inlay, onlay, veneer or partial coverage restoration	$10
D2915	Recement or re-bond cast indirectly fabricated or prefabricated post and core	$10
D2920	Recement or re-bond crown	$10
D2921	Reattachment of tooth fragment, incisal edge or cusp	$65
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$80
D2930	Prefabricated stainless steel crown - primary tooth	$60
D2931	Prefabricated stainless steel crown - permanent tooth	$60
D2932	Prefabricated resin crown	$45
D2933	Prefabricated stainless steel crown with resin window	$60
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$60
D2940	Protective restoration	$10
D2941	Interim therapeutic restoration-primary dentition	$5
D2950	Core buildup, including any pins when required	$70
D2951	Pin retention - per tooth, in addition to restoration	$15
D2952	Cast post and core in addition to crown	$50
D2953	Each additional indirectly fabricated post, same tooth	$50
D2954	Prefabricated post and core in addition to crown	$30
D2955	Post removal	$10

D2957	Each additional prefabricated post, same tooth	$30
D2960	Labial veneer (resin laminate) - direct	$270
D2961	Labial veneer (resin laminate) - indirect	$465
D2962	Labial veneer (porcelain laminate) - indirect	$560
D2971	Additional procedures to customize a crown to fit under an existing partial dental framework	$50
D2975	Coping	$80
D2980	Crown repair necessitated by restorative material failure	$45
D2990	Resin infiltration of incipient smooth surface lesions	$5
Endodontic Services		
D3110	Pulp cap - direct (excluding final restoration)	$5
D3120	Pulp cap - indirect (excluding final restoration)	$5
D3220	Therapeutic pulpotomy (excluding final restoration)	$25
D3221	Pulpal debridement, primary and permanent teeth	$55
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$40
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$125
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$215
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$365
D3331	Treatment of root canal obstruction, non-surgical access	$115
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$115
D3333	Internal root repair of perforation defects	$115
D3346	Retreatment of previous root canal therapy - anterior	$155
D3347	Retreatment of previous root canal therapy - bicuspid	$245
D3348	Retreatment of previous root canal therapy - molar	$415
D3351	Apexification/recalcification-initial visit (apical closure/ calcific repair of perforations, root resorption, etc.	$70
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement	$70
D3353	Apexification/recalcification - final visit (includes completed root	$70
D3355	Pupal regeneration-initial visit	$65
D3356	Pulpal regeneration-interim medicament replacement	$65
D3357	Pulpal regeneration-completion of treatment	$65
D3410	Apicoectomy - anterior	$115

D3421	Apicoectomy - premolar (first root)	$125
D3425	Apicoectomy - molar (first root)	$140
D3426	Apicoectomy (each additional root)	$95
D3430	Retrograde filling - per root	$60
D3450	Root amputation - per root	$110
D3460	Endodontic endosseous implant	$970
D3471	Surgical repair of root resorption - anterior	$115
D3472	Surgical repair of root resorption - premolar	$125
D3473	Surgical repair of root resorption - molar	$140
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	$250
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	$250
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	$250
D3910	Surgical procedure for isolation of tooth with rubber dam	$25
D3911	Intraorifice barrier	$65
D3920	Hemisection (including any root removal), not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$15
Periodontic Services		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$95
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$15
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bound spaces per quadrant	$160
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bound spaces per quadrant	$115
D4245	Apically positioned flap	$175
D4249	Clinical crown lengthening - hard tissue	$175
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$385
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$300
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$235
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	$90

D4270	Pedicle soft tissue graft procedure	$255
D4274	Mesial/distal wedge procedure single tooth (when not performed in conjunction with surgical procedures in the same area	$100
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth	$235
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous position	$275
D4322	Splint - intra-coronal; natural teeth or prosthetic crowns	$75
D4323	Splint - extra-coronal; natural teeth or prosthetic crowns	$75
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55
D4342	Periodontal scaling and root planing - one - three teeth, per quadrant	$55
D4346	Scaling in presence of generalized moderate or severe gingival inflammation	$40
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$55
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$65
D4910	Periodontal maintenance	$40
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$0
D4921	Gingival irrigation with a medicinal agent - per quadrant	$0
Removable Prosthodontic Services		
D5110	Complete denture - maxillary	$425
D5120	Complete denture - mandibular	$425
D5130	Immediate denture - maxillary	$440
D5140	Immediate denture - mandibular	$440
D5211	Maxillary partial denture - resin base (including retentive/ clasping materials, rests, and teeth)	$400
D5212	Mandibular partial denture - resin base (including retentive/ clasping materials, rests, and teeth)	$400
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests	$450
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rest	$450
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$160
D5222	Immediate mandibular partial denture - resin base	$170

D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping material	$160
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping material	$170
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	$450
D5226	Mandibular partial denture - flexible base (including any retentive/clasping materials, rests, and teeth)	$450
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	$160
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	$170
D5282	Removable unill. partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	$330
D5283	Removable unill. partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	$330
D5284	Removable unill. part denture - one piece flex. base (including retentive/clasping materials, rests, and teeth), per quadrant	$450
D5286	Removable unill. part denture - one piece resin (including retentive/clasping materials, rests, and teeth), per quadrant	$450
D5410	Adjust complete denture - maxillary	$15
D5411	Adjust complete denture - mandibular	$15
D5421	Adjust partial denture - maxillary	$15
D5422	Adjust partial denture - mandibular	$15
D5511	Repair broken complete denture base, mandibular	$15
D5512	Repair broken complete denture base, maxillary	$15
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40
D5611	Repair resin partial denture base, mandibular	$15
D5612	Repair resin partial denture base, maxillary	$15
D5621	Repair cast partial framework, mandibular	$15
D5622	Repair cast partial framework, maxillary	$15
D5630	Repair or replace broken retentive/clasping materials - per tooth	$40
D5640	Replace broken teeth - per tooth	$40
D5650	Add tooth to existing partial denture	$40
D5660	Add clasp to existing partial denture - per tooth	$50

D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165
D5710	Rebase complete maxillary denture	$105
D5711	Rebase complete mandibular denture	$105
D5720	Rebase maxillary partial denture	$105
D5721	Rebase mandibular partial denture	$105
D5725	Rebase hybrid prosthesis	$105
D5730	Reline complete maxillary denture (direct)	$90
D5731	Reline complete mandibular denture (direct)	$90
D5740	Reline maxillary partial denture (direct)	$90
D5741	Reline mandibular partial denture (direct)	$90
D5750	Reline complete maxillary denture (indirect)	$115
D5751	Reline complete mandibular denture (indirect)	$115
D5760	Reline maxillary partial denture (indirect)	$115
D5761	Reline mandibular partial denture (indirect)	$115
D5765	Soft liner for complete or partial removable denture - indirect	$35
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), (maxillary)	$160
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), (mandibular)	$170
D5850	Tissue conditioning, maxillary	$35
D5851	Tissue conditioning, mandibular	$35
D5863	Overdenture-complete maxillary	$425
D5864	Overdenture-partial maxillary	$450
D5865	Overdenture - complete mandibular	$425
D5866	Overdenture-partial mandibular	$450
D5876	Add metal substructure to acrylic full denture (per arch)	$105
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	$1,035
D6013	Surgical placement of mini-implant	$1,185
D6055	Connecting bar - implant supported or abutment supported	$390
D6056	Prefabricated abutment - includes modification and placement	$290
D6057	Custom fabricated abutment - includes placement	$395
D6058	Abutment supported porcelain/ceramic crown	$710
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$860
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$575

D6061	Abutment supported porcelain fused to metal crown (noble metal)	$785
D6062	Abutment supported cast metal crown (high noble metal)	$825
D6063	Abutment supported cast metal crown (predominantly base metal)	$595
D6064	Abutment supported cast metal crown (noble metal)	$770
D6065	Implant supported porcelain/ceramic crown	$740
D6066	Implant supported - porcelain fused to high noble alloys	$870
D6067	Implant supported crown - high noble alloys	$730
D6068	Abutment supported retainer for porcelain/ceramic FPD	$680
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$855
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$630
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$830
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$840
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$630
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$820
D6075	Implant supported retainer for ceramic FPD	$740
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$855
D6077	Implant supported retainer for metal FPD - high noble alloys	$665
D6080	Implant maintenance procedures when prostheses are removed and reinserted	$80
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$870
D6083	Implant supported crown - porcelain fused to noble alloys	$870
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$870
D6086	Implant supported crown - predominantly base alloys	$730
D6087	Implant supported crown - noble alloys	$730
D6088	Implant supported crown - titanium and titanium alloys	$730
D6090	Repair implant supported prosthesis, by report	$130
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment	$200
D6092	Recement or re-bond implant/abutment supported crown	$60
D6093	Recement or re-bond implant/abutment supported fixed partial denture	$80

D6094	Abutment supported crown - titanium and titanium alloys	$710
D6095	Repair implant abutment, by report	$150
D6096	Remove broken implant retaining screw	$150
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$860
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$855
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$855
D6100	Surgical removal of implant body	$250
D6101	Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	$255
D6102	Debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces	$315
D6103	Bone graft for repair of periimplant defect not including flap entry and closure	$265
D6105	Removal of implant body not requiring bone removal nor flap elevation	$250
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$925
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$925
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$925
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$925
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$855
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$665
D6122	Implant supported retainer for metal FPD - noble alloys	$665
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$665
D6190	Radiographic/surgical implant index, by report	$145
D6191	Semi-precision abutment - placement	$525
D6192	Semi-precision attachment - placement	$525
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$725
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$855

D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis	$150
Fixed Prosthodontic Services		
D6205	Pontic - indirect resin based composite	$250
D6210	Pontic - cast high noble metal	$305
D6211	Pontic - cast predominantly base metal	$305
D6212	Pontic - cast noble metal	$305
D6214	Pontic - titanium and titanium alloys	$305
D6240	Pontic - porcelain fused to high noble metal	$305
D6241	Pontic - porcelain fused to predominantly base metal	$305
D6242	Pontic - porcelain fused to noble metal	$305
D6243	Pontic - porcelain fused to titanium and titanium alloys	$305
D6245	Pontic - porcelain/ceramic	$350
D6250	Pontic - resin with high noble metal	$250
D6251	Pontic - resin with predominantly base metal	$250
D6252	Pontic - resin with noble metal	$250
D6253	Interim pontic - further treatment or completion of diagnosis necessary prior to final impression	$175
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$250
D6548	Retainer-porcelain/ceramic for resin bonded fixed prosthesis	$300
D6549	Resin retainer - for resin bonded fixed prosthesis	$85
D6600	Retainer inlay-porcelain/ceramic, two surfaces	$325
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$325
D6602	Retainer inlay - cast high noble metal, two surfaces	$200
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$200
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$200
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$200
D6606	Retainer inlay - cast noble metal, two surfaces	$200
D6607	Retainer inlay - cast noble metal, three or more surfaces	$200
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$335
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$335
D6610	Retainer onlay - cast high noble metal, two surfaces	$200
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$200
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$200
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$200

D6614	Retainer onlay - cast noble metal, two surfaces	$200
D6615	Retainer onlay - cast noble metal, three or more surfaces	$200
D6624	Retainer inlay - titanium	$305
D6634	Retainer onlay - titanium	$305
D6710	Retainer crown - indirect resin based composite (not to be used as a temporary or provisional crown)	$185
D6720	Retainer crown - resin with high noble metal	$250
D6721	Retainer crown - resin with predominantly base metal	$250
D6722	Retainer crown - resin with noble metal	$250
D6740	Retainer crown - porcelain/ceramic	$350
D6750	Retainer crown - porcelain fused to high noble metal	$305
D6751	Retainer crown - porcelain fused to predominantly base metal	$305
D6752	Retainer crown - porcelain fused to noble metal	$305
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$305
D6780	Retainer crown - 3/4 cast high noble metal	$305
D6781	Retainer crown - 3/4 cast predominantly based metal	$305
D6782	Retainer crown - 3/4 cast noble metal	$305
D6783	Retainer crown - 3/4 porcelain/ceramic	$305
D6784	Retainer crown - 3/4titanium and titanium alloys	$305
D6790	Retainer crown - full cast high noble metal	$305
D6791	Retainer crown - full cast predominantly base metal	$305
D6792	Retainer crown - full cast noble metal	$305
D6794	Retainer crown - titanium and titanium alloys	$305
D6920	Connector bar	$85
D6930	Recement or re-bond fixed partial denture	$10
D6940	Stress breaker	$150
D6980	Fixed partial denture repair, necessitated by restorative material failure	$140
Oral Surgery Services		
D7111	Extraction, coronal remnants - primary tooth	$10
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$15
D7210	Extraction, erupted tooth req removal of bone, sectioning of tooth and including elevation of mucoperiosteal flap	$50
D7220	Removal of impacted tooth - soft tissue	$65
D7230	Removal of impacted tooth - partially bony	$95
D7240	Removal of impacted tooth - completely bony	$135
D7241	Removal of impacted tooth - completely bony, with unusual surgical	$155
D7250	Removal of residual tooth roots (cutting procedure)	$40

D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	$0
D7261	Primary closure of a sinus perforation	$225
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$80
D7280	Exposure of an unerupted tooth	$120
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$120
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	$150
D7286	Incisional biopsy of oral tissue - soft (all others)	$60
D7287	Exfoliative cytological sample collection	$20
D7288	Brush biopsy - transepithelial sample collection	$20
D7290	Surgical repositioning of teeth	$75
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$60
D7311	Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces, per quadrant	$45
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$80
D7321	Alveoloplasty not in conjunction with extraction - one to three teeth or tooth spaces, per quadrant	$60
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$215
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment	$670
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$70
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$110
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$100
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$125
D7471	Removal of lateral exostosis (maxilla or mandible)	$100
D7472	Removal of torus palatinus	$100
D7473	Removal of torus mandibularis	$100
D7485	Reduction of osseous tuberosity	$100
D7509	Marsupialization of odontogenic cyst	$70
D7510	Incision and drainage of abscess - intraoral soft tissue	$40
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$60
D7520	Incision and drainage of abscess - extraoral soft tissue	$70

D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$190
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$40
D7881	Occlusal orthotic device adjustment	$15
D7910	Suture of recent small wounds up to 5 cm	$25
D7961	Buccal / labial frenectomy (frenulectomy)	$90
D7962	Lingual frenectomy (frenulectomy)	$90
D7963	Frenuloplasty	$90
D7970	Excision of hyperplastic tissue - per arch	$55
D7971	Excision of pericoronal gingiva	$40
D7972	Surgical reduction of fibrous tuberosity	$100
Adjunctive General Services		
D9110	Palliative treatment of dental pain - per visit	$10
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$0
D9222	Deep sedation/general anesthesia - first 15 minutes	$75
D9223	Deep sedation/general anesthesia - each 15 minute increment	$75
D9239	Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes	$70
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$70
D9248	Non-intravenous conscious sedation. This includes non-iv minimal and moderate sedation.	$50
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$25
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$5
D9440	Office visit - after regularly scheduled hours	$35
D9450	Case presentation, subsequent to detailed and extensive treatment planning	$0
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$0
D9943	Occlusal adjustment	$15
D9944	Occlusal guard - hard appliance, full arch	$35
D9945	Occlusal guard - soft appliance, full arch	$35
D9946	Occlusal guard - hard appliance, partial arch	$35
D9951	Occlusal adjustment - limited	$35

D9952	Occlusal adjustment - complete	$100
D9971	Odontoplasty - per tooth	$20
D9972	External bleaching-per arch-performed in office	$125
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$125
D9995	Teledentistry - synchronous; real-time encounter	$0
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	$0
D9999	Unspecified adjunctive procedure, by report	$20

General provisions for routine dental services

Dentists are independent agents

We do not undertake to directly furnish any health care services. Our obligations are limited to the payment for health care service provided to you by dentists who are independent agents.

Dental records
We shall have access to dental and treatment records of members to determine benefits, process claims, utilization review, quality assurance, financial audit, or for any other purpose reasonably related to covered dental services. Each member shall complete and submit to us such additional consents, releases and other documents as may be requested in order to determine or provide benefits. We reserve the right to reject or suspend a claim based on lack of supporting dental information or records.

Recovery of payments
We reserve the right to deduct from any benefits properly payable under the dental benefit the amount of any payment that has been made:

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

Discharge of liability
Any payment made in accordance with the provisions of the dental benefit shall fully discharge our liability to the extent of such payment.

Routine hearing services

Covered Services

The following services are covered under your additional hearing benefit:

Routine Hearing Exam

- You can receive a complete hearing exam, every year through a UnitedHealthcare Hearing provider.
- Contact UnitedHealthcare Hearing at 1-866-445-2071, TTY 711 to find a provider.

Please see the Medical Benefits Chart above for any copayment or coinsurance that may be due at the time of your exam.

Hearing Aids (Includes digital hearing aids)

Hearing service providers
Your health plan network hearing aid provider, UnitedHealthcare Hearing, can help get you started. You can contact UnitedHealthcare Hearing at 1-866-445-2071, TTY 711, 8 a.m.-8 p.m. CT, Monday-Friday or by visiting UHCHearing.com/retiree. A hearing counselor will verify eligibility and help in determining your hearing care needs. Then they will help you find a convenient location and make your appointment.

Please note:

- Hearing aid units are medical devices that fit in or near the ear.
- This benefit may cover more than one year, but it may be changed or terminated at the end of the plan year.
- There is no coverage if hearing aids or related services are received from an out-of-network provider.
- A hearing aid purchase includes:
- 1 hearing exam for evaluation and fitting of hearing aids every year
- A trial period
- 3 hearing aid follow-up appointments within the first year
  - 1 follow-up appointment for hearing aids purchased in the Silver technology level
- A 3-year extended warranty

Check the Medical Benefits Chart above for the amount of your benefit and how often you can purchase hearing aids.

Limitations and exclusions

The limitations and exclusions below apply to your additional hearing aid benefit:

- Hearing aids ordered through providers other than UnitedHealthcare Hearing are not covered
- Government treatment for any services provided in a local, state or federal government facility or agency except when payment under the plan is expressly required by federal or state law.
- Any treatment or services caused by or arising out of the course of employment or covered under any public liability insurance, including, but not limited to, Worker's Compensation programs.
- Covered expenses related to hearing aids are limited to plan Usual and Customary (U&C) charge of a basic hearing aid to provide functional improvement. Certain hearing aid items and services are not covered. Items and services that are not covered include, but are not limited to, the following:
  - Replacement of a hearing aid that is lost, broken or stolen if occurrence exceeds covered rate of occurrence
  - Repair of the hearing aid and related services
  - An eyeglass-type hearing aid or additional charges for a hearing aid designed specifically for cosmetic purposes

- Coverage must be active on the date of service to utilize the benefit
- Services, accessories, or supplies that are not medically necessary according to professionally accepted standards of practice
- Replacement batteries or assistive listening devices
- The plan does not cover hearing services obtained outside of the warranty or trial period
- Services you choose to have that are not covered under the benefit will be at your own cost

Routine Vision Services

Vision service providers

If you belong to one of the network medical groups/IPAs listed below, you will receive your routine vision services through your medical group/IPA. Contact your medical group/IPA office to make an appointment.

California
Alamitos IPA
Beaver Medical Group
Optum IPA South Bay
Optum East Los Angeles
Optum El Monte
Optum Glendale
Optum Los Angeles
Optum Montebello
Optum South Bay
Optum Willow, Katella, and Walker Sites
Lakewood IPA

This list is subject to change. If you need an updated list of providers or don't know which medical group/IPA you currently belong to, please call Customer Service at the phone number listed in Chapter 2.

If you don’t belong to any of these medical groups, you will receive your routine vision services through UnitedHealthcare Vision®.

- To find a provider, go to medicare.myuhcvision.com.
- To schedule an appointment, call your selected provider's office.
- When you go to the provider's office for services, you may be asked to show your member ID card.
- If applicable, you will also need to pay the appropriate copayment or coinsurance at the time of your service.
- The vision directory is subject to change.

Covered services

The following services are covered under your vision benefit:

Routine eye exam

A routine vision exam every 12 months, through a network vision provider.

Routine eyewear

The plan provides an eyewear benefit for vision correction not related to cataract surgery. Eyewear consists of frames and lenses (eyeglasses) or contact lenses.

For routine vision services from an out-of-network vision or eyewear provider, you may need to pay the full cost of the service and then submit to UnitedHealthcare for reimbursement. For more information on this process, please see 7.

Standard lenses include standard single vision, lined bifocal, lined trifocal, lenticular, and standard progressive lenses.

Note: Coverage for contact lenses are limited to 8 boxes from a select list.

Please refer to the **Medical Benefits Chart** above for details about your routine eyewear benefit.

Limitations and exclusions

The limitations and exclusions below apply to your routine vision benefit:

- Medically necessary services covered under Original Medicare.
- Government treatment for any services provided in a local, state or federal government facility or agency, except when federal or state law requires payment under the plan.
- Any treatment or services caused by or resulting from employment, or covered under any public liability insurance, including Worker's Compensation programs.
- Orthoptics or vision training and any associated supplemental testing.
  - Plano lenses (non-prescription).
  - 2 pair of glasses instead of bifocals.
  - Subnormal (low) vision aids.
  - Replacement of lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
  - LASIK, surgeries or other laser procedures.
  - Any eye exam or corrective eyewear required by an employer as a condition of employment.
  - Contact fitting 92310, is separate from a routine exam and would be 100% member responsibility.

Routine Chiropractic Services

Chiropractic service providers

Your health plan network chiropractic service provider, ACN Group of California, Inc. dba OptumHealth Physical Health of California (Optum) may be reached at **1-800-428-6337** (TTY **1-888-877-5378**).

Covered services

The following services are covered under your additional chiropractic benefit:

- A limited number of visits per year, including evaluation of X-rays.
- An initial exam with a chiropractor to determine the nature of your problem and prepare a treatment plan if necessary.
- Follow-up visits to chiropractors, as indicated by a treatment plan, which may include spinal and extraspinal manipulations, therapy, X-ray procedures and laboratory tests.
- Conjunctive therapy as indicated by the treatment plan, which may include an ultrasound and electrical muscle stimulation.
- A re-evaluation to assess the need to continue, extend or change your treatment plan. If a separate appointment is made to re-evaluate your treatment plan, it will count as a visit and a copayment or coinsurance will be required.
- X-rays and laboratory tests are covered in full when prescribed by a chiropractor. X-ray interpretations or consultations are only covered when medically necessary and performed by a chiropractor or an American Radiology Association (ARA) radiologist.

Please refer to the Medical Benefits Chart above for your copayment or coinsurance and the number of visits allowed under this plan.

Limitations and exclusions

The limitations and exclusions below apply to your additional chiropractic benefit:

- Government treatment for any services provided in a local, state or federal government facility or agency, except when federal or state law requires payment under the plan.
- Any treatment or services caused by or resulting from employment, or covered under any public liability insurance, including Worker's Compensation programs.
- Terms and conditions of coverage not outlined in the Evidence of Coverage.
- Any accommodation, service, supply or other item determined not to be medically necessary, except for routine covered chiropractic services.
- Any service or treatment from an out-of-network chiropractor, except for emergency chiropractic services.
- Services for an exam or treatment of strictly non-neuromuscular-skeletal disorders.
- Services that are not documented as necessary and appropriate, or are experimental or investigational chiropractic care.
- Diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scans and/or other types of diagnostic scanning.

- Any services or treatment for Temporomandibular Joint Disease (TMJ). TMJ is a condition of the jaw joint that commonly causes headaches, tenderness of the jaw muscles or dull aching facial pain.
- Treatment or service for pre-employment physicals or vocational rehabilitation.
- Thermography.
- Hypnotherapy, behavior training, sleep therapy, weight programs, educational programs, non-medical self-care or self-help including any self-help physical exercise training, or any related diagnostic testing.
- Air conditioners, air purifiers, therapeutic mattress supplies or any other similar devices or appliances.
- Vitamins, minerals, nutritional supplements or other similar-type products.
- Manipulation under anesthesia, hospitalization or any related services.
- Prescription drugs or medicines, including non-legend or proprietary medicine, that don't require a prescription order.

Chapter 5

Using the plan's coverage for Part D prescription drugs

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.

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 you a 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 references. (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 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 **Pharmacy Directory**, visit our website (retiree.uhc.com), and/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 pharmacy in your area, you can get help from

Customer Service or use the **Pharmacy Directory**. You can also find information on our website at retiree.uhc.com.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have 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 **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 **up to a 90-day supply**.

To get order forms and information about filling your prescriptions by mail you may contact our preferred mail service pharmacy, OptumRx™. OptumRx can be reached at 1-888-279-1828, or for the hearing impaired, (TTY) 711, 24 hours a day, 7 days a week. Please reference your **Pharmacy Directory** to find the mail service pharmacies in our network. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will be delivered to you in no more than 10 business days. However, sometimes your mail-order may be delayed. If your mail-order is delayed, please follow these steps:

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

New prescriptions the pharmacy 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 at any time by phone or mail.

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

If you used mail order in the past and 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. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you 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 but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 10 days before your current prescription will run out. This will ensure your order is shipped to you in time.

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

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

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

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

When you get a long-term supply of drugs, your cost-sharing may be lower. The plan offers 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.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your **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.
2. 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. To help you, we have network pharmacies outside of our service area where

you can get your prescriptions filled as a member of our plan. **Please check first with Customer Service** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

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 Drug List without restrictions, and are not excluded from Medicare Part D coverage.
- **Coverage when traveling or out of the service area**
  When traveling within the U.S. you have access to network pharmacies nationwide. Bring your prescriptions and medication with you and be sure to check the pharmacy directory for your travel plans to locate a network pharmacy while traveling. If you are leaving the country, you may be able to obtain a greater day supply to take with you before leaving for the country where there are no network pharmacies available.
- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy that provides 24-hour service is not within reasonable driving distance.
- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- If you need a prescription while a patient in an emergency department, provider based clinic, outpatient surgery, or other outpatient setting.

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 (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2 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 drugs on the Drug List are only those covered under Medicare Part D.

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 drugs and generic drugs.

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

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 cost less. There are generic drug substitutes available for many brand name drugs.

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 the 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 9.

Section 3.2 There are 4 "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of 4 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

Tier 1 – Preferred Generic - Most generic drugs.

Tier 2 – Preferred Brand - Many common brand name drugs, called preferred brands, and some higher-cost generic drugs.

Tier 3 – Non-preferred Drug - Non-preferred generic and non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in Tier 3.

Tier 4 – Specialty Tier - Unique and/or very high-cost brand and generic drugs.

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

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 **(What you pay for your Part D prescription drugs)**.

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Visit the plan's website (retiree.uhc.com) for the most current information.
2. 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.
3. Use the plan's "Real-Time Benefit Tool" (retiree.uhc.com or by calling Customer Service). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

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 ways. 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 or cost-sharing 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 9)

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. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

What is a compounded drug?

A compounded drug is created by a pharmacist by combining or mixing ingredients to create a prescription medication customized to the needs of an individual patient.

Does my Part D plan cover compounded drugs?

Generally compounded drugs are non-formulary drugs (not covered) by your plan. You may need to ask for and receive an approved coverage determination from us to have your compounded drug covered. Compounded drugs may be Part D eligible if they meet all of the following requirements:

1. Contains at least one FDA, or Compendia, approved drug ingredient, and all ingredients in the compound (including their intended route of administration) are supported in the Compendia.

2. Does not contain a non-FDA approved or Part D excluded drug ingredient
3. Does not contain an ingredient covered under Part B. (If it does, the compound may be covered under Part B rather than Part D)
4. Prescribed for a medically accepted condition

The chart below explains the basic requirements for how a compound with 2 or more ingredients may or may not be covered under Part D rules, as well as potential costs to you.

Compound Type	Medicare Coverage
Compound containing a Part B eligible ingredient	Compound is covered only by Part B
Compound containing all ingredients eligible for Part D coverage and all ingredients are approved for use in a compound	Compound may be covered by Part D upon approved coverage determination
Compound containing ingredients eligible for Part D coverage and approved for use in a compound, and ingredients excluded from Part D coverage (for example, over the counter drugs, etc.)	Compound may be covered by Part D upon approved coverage determination. However, the ingredients excluded from Part D coverage will not be covered and you are not responsible for the cost of those ingredients excluded from Part D coverage
Compound containing an ingredient not approved or supported for use in a compound	Compound is not covered by Part D. You are responsible for the entire cost

What do I have to pay for a covered compounded drug?

A compounded drug that is Part D eligible may require an approved coverage determination to be covered by your plan. You will pay the non-preferred drug copay or coinsurance amount for compounded drugs that are approved. No further tier cost share reduction is allowed or available.

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan 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, 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 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 drug list (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.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be.
- 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.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 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 plan year.
- This temporary supply will be for at least a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to at least a 30-day supply 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 at least a 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For those current members with level of care changes:**
  There may be unplanned transitions such as hospital discharges (including psychiatric hospitals) or level of care changes (i.e., changing long-term care facilities, exiting and entering a long-term care facility, ending Part A coverage within a skilled nursing facility, or ending hospice coverage and reverting to Medicare coverage) that can occur anytime. If you are prescribed a drug that is not on our Drug List or your ability to get your drugs is restricted in some way, you are required to use the plan's exception process. For most drugs, you may request a one-time temporary supply of at least 30 days to allow you time to discuss alternative treatment with your doctor or to request a Drug List (formulary) exception. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 30 day supply.

For questions about a temporary supply, call Customer Service.

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 are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 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 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

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

You can change to another drug

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

You can ask for an exception

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells 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.

Drugs in our Specialty Tier are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

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 plan year. However, during the year, the plan can make some changes to the Drug List. For example, the plan might:

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

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, we post information on our website about those changes. We also update our website 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

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
  - 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 on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both 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 9.
- **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 change the cost-sharing tier 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 the change, you should work with your provider to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
  - 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 9.

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

If any of these changes happen for a drug you 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 or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or 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 Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. 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 9.)

Here are four 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 or 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 are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs).
- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.
- Drugs used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs used for the treatment of sexual or erectile dysfunction.
- Drugs used for treatment of anorexia, weight loss, or weight gain.

- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

Please note: Your plan sponsor **may** have elected to offer some of the drugs listed above to you as an additional benefit. If so, you will receive additional information about the drugs they have chosen to offer to you separately, in your plan materials.

In addition, if you are **receiving Extra Help** from Medicare to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. (Please refer to the plan's Drug List or call Customer Service for more information.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

Section 8 Filling a prescription

Section 8.1 Provide your UnitedHealthcare member ID information

To fill your prescription, provide your UnitedHealthcare member ID information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for **our** share of your drug cost. You will need to pay the pharmacy **your** share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your UnitedHealthcare member ID 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, or you can ask the pharmacy to look up your plan enrollment 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** for our share. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

Section 9 Part D drug coverage in special situations

Section 9.1 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 prescription 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 uses 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 **Pharmacy Directory** to find out if your LTC facility's pharmacy or the one that it uses 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 also getting drug coverage from an employer or another retiree group plan?

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

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be **secondary** to your group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next plan year is "creditable."

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep this notice about creditable coverage, because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need this notice to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 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 drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because they are unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drugs are unrelated before our plan can cover the drugs. 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 may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain 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 tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. 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 decision 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 9 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, 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) programs to help members manage their medications

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

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

Chapter 6

What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider."

Section 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. Your Plan Sponsor has chosen to make supplemental drug coverage available to you. This coverage is in addition to your Part D prescription drug benefit. **Section 5.2 of this chapter contains a table that shows your costs for a** drug that is covered by both your Part D prescription drug benefit and your supplemental drug coverage. For more information about this supplemental drug coverage you can view the Certificate of Coverage at retiree.uhc.com or call Customer Service to have a hard copy sent to you. Your plan sponsor offers additional prescription drug coverage. Please see your Additional Drug Coverage list for more information. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 5, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real-Time Benefit Tool" by calling Customer Service.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you pay for drugs before our plan begins to pay its share.
- **"Copayment"** is a fixed amount you pay each time you fill a prescription.
- **"Coinsurance"** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does **not** count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Initial Coverage Stage
  - The Coverage Gap Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs.
- These payments are **also included** in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included in your out-of-pocket costs. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $8,000 in out-of-pocket costs within the plan year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.

- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Service.

How can you keep track of your out-of-pocket total?

- **We will help you**. The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $8,000, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

Section 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for our plan members?

There are four "drug payment stages" for your prescription drug coverage under UnitedHealthcare® Group Medicare Advantage (HMO). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

Section 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 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. This way, we can tell you when

you have moved from one drug payment stage to the next. 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 (what you pay including coverage gap discount program payments).
- 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.

If you have had one or more prescriptions filled through the plan during the previous month we will send you a Part D EOB. 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 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.
- **Available lower cost alternative prescriptions**. This will include information about other available drugs with lower cost-sharing for each prescription claim.

Section 3.2 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 UnitedHealthcare member ID card when you get a prescription filled**. This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need**. There are times you may pay for the entire cost of a prescription drug. In these cases, we 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, give us copies of these receipts. Here are examples of when you should give us copies of your drug receipts:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - 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 our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others have made for you**. Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and

most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive a Part D EOB look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Customer Service. You can also view your EOB on our website at retiree.uhc.com. Be sure to keep these reports.

Section 4 There is no deductible for the plan

Your plan provides additional coverage, which means you do not pay a deductible for your Part D drugs. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

Section 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has 4 cost-sharing tiers

Every drug on the plan's Drug List is in one of 4 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

Tier 1 – Preferred Generic - Most generic drugs.

Tier 2 – Preferred Brand - Many common brand name drugs, called preferred brands, and some higher-cost generic drugs.

Tier 3 – Non-preferred Drug - Non-preferred generic and non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in Tier 3.

Tier 4 – Specialty Tier - Unique and/or very high-cost brand and generic drugs.

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

Your pharmacy choices

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

- A network retail pharmacy
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's **Pharmacy Directory**.

Section 5.2 A table that shows your costs for a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier. Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a 30-day supply and a long-term 90-day supply of a drug.

Your share of the cost when you get a covered Part D prescription drug:

Tier	**Standard retail cost-sharing (in-network)** (30-day supply)	**Mail-order cost-sharing** (90-day supply)	**Out-of-network cost-sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (30-day supply)
Cost-Sharing Tier 1 Preferred Generic	$5 copayment	$10 copayment	$5 copayment*
Cost-Sharing Tier 2 Preferred Brand [1]	$15 copayment	$30 copayment	$15 copayment*
Cost-Sharing Tier 3 Non-preferred Drug [1]	$30 copayment	$60 copayment	$30 copayment*
Cost-Sharing Tier 4 Specialty Tier [1]	$30 copayment	$60 copayment	$30 copayment*

[1] You will pay a maximum of $35 for a 1-month supply of each Part D insulin product covered by our plan.

*You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

If you obtain less than a 90-day supply from the mail-order pharmacy for any reason, the in-network standard retail cost-sharing amount applies.

Please see Section 9 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach $5,030

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$5,030 limit for the Initial Coverage Stage**.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $5,030 limit in a year.
We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

Section 6 Costs in the Coverage Gap Stage

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are on the cover of this booklet).

After you leave the Initial Coverage Stage, we will continue to pay our share of the cost of your drugs and you pay your share of the cost. You pay these amounts until your yearly out-of-pocket costs reach a maximum amount that Medicare has set. In 2024, that amount is $8,000.

Medicare has rules about what counts and what does not count toward your out-of-pocket costs (Section 1.3).

Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines.

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 9 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.

Section 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs

- You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this payment stage, the plan pays the full cost for your covered drugs. You pay nothing.

Section 8 Additional benefits information

This part of Chapter 6 talks about limitations of our plan.

1. Medications will not be covered if prescribed by physicians or other providers who are excluded or precluded from the Medicare program participation.
2. You may refill a prescription when a minimum of seventy-five percent (75%) of the quantity is consumed based on the days supply.
3. Costs for drugs that are not covered under Part D do not count toward your Out-of-Pocket costs.

Section 9 Part D Vaccines. What you pay for depends on how and where you get them

Important message about what you pay for vaccines – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. Refer to your plan's Drug List or contact Customer Service for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.

- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what drug payment stage you are in.

Below are 4 examples of ways you might get a Part D vaccine.

Situation 1: You get your vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give certain vaccines.) Your cost-share may be lower when you use a network pharmacy.

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay the pharmacy your coinsurance OR copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office and they submit a claim on your behalf.

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay your doctor your coinsurance OR copayment for the vaccine itself which includes the cost of giving you the vaccine. (Your doctor is not allowed to charge you more than your plan approved cost-share.)
- Our plan will pay the remainder of the costs.

Situation 3: You get the Part D vaccine at your doctor's office and ask them not to submit a claim on your behalf. (Your doctor is required to submit a claim unless you ask them not to.)

- Before giving you the vaccine, your doctor must tell you what your out-of-pocket costs will be.
- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.

- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less your normal coinsurance OR copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get “Extra Help,” we will reimburse you for this difference.)

Situation 4: You buy the Part D vaccine itself at your pharmacy, and then take it to your doctor’s office where they give you the vaccine.

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will have to pay the pharmacy your coinsurance OR copayment for the vaccine itself.
- When your doctor gives you the vaccine, they will submit a claim for the administration of the vaccine. Depending on which drug payment stage you're in, you may have to pay an additional coinsurance OR copayment.
- If you ask your doctor not to submit a claim, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance OR copayment for the vaccine administration, and less any difference between the amount the doctor charges and what we normally pay. (If you get “Extra Help,” we will reimburse you for this difference.)

Chapter 7

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

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

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In these cases, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services 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.

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

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

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

Outside the service area, you can receive emergency or urgently needed services from any provider in the United States, whether or not the provider is a part of our network. In these cases,

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

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

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

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

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

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

3. If you are retroactively enrolled in our plan

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

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

4. When you 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 for our share of the cost. 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 member ID card with you

If you do not have your UnitedHealthcare 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 for our share of the cost.

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 **Drug List** 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 our share of the cost.

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 for the difference between the amount of your bill and your cost share for the services as outlined in Chapter 4 of this document.
- Save all of your receipts and send us copies when you ask us to pay you back. In some situations, we may need to get more information from you or the provider who rendered services to you in order to pay you back for our share of the cost. Please see Chapter 7 Section 2.1 for expense reimbursement for worldwide services.
- If you are being asked to pay your bill for worldwide emergency services and are unable to make the payment, please call Customer Service for additional assistance and we may be able to help coordinate payment for covered services on your behalf.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

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

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

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

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

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

Medical claims payment requests:
UnitedHealthcare
P.O. Box 30968
Salt Lake City, UT 84130-0968

Part D prescription drug payment requests:
OptumRx
P.O. Box 650287
Dallas, TX 75265-0287

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

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

Section 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 and how much we owe

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

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

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

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

Chapter 8

Your rights and responsibilities

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

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

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

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

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

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

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

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 (Chapter 3 explains more about this). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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

How to Receive Care After Hours

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

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

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

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that 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. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

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

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

HEALTH PLAN NOTICE OF PRIVACY PRACTICES

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

Effective January 1, 2024

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

The terms “information” or “health information” in this notice include information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

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

How We Collect, Use, and Disclose Information

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

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

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

- **For Payment** of premiums owed to us, to determine your health care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment**, including to aid in your treatment or the coordination of your care. For example, we share information with other doctors to help them provide medical care to you.
- **For Health Care Operations** as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.
- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors,** if your coverage is through an employer sponsored group health plan. We may share summary health information and enrollment and disenrollment information with the plan sponsor. We also may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes;** however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information in risk rating and pricing such as age and gender, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders,** we may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment or health care operations using telephone numbers or email addresses you provide to us.

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

- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who help pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others. We may disclose health information to any persons involved, prior to the death, in the care or payment

for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements, or for certain activities related to preparing a research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Donation Purposes** to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information.

- **Additional Restrictions on Use and Disclosure.** Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. Such laws may protect the following types of information:

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

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

Except for uses and disclosures described in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain marketing communications, without your written authorization. Once you give us authorization to use or disclose your health information, you may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. For information on how to revoke your authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

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

- **You have the right to ask to restrict** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Any request for restrictions must be made in writing. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any request for a restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with

applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to request to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send a copy of your health information in an electronic format to you. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting. Any request for an accounting must be made in writing.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your website.
- **In certain states, you may have the right to request that we delete** your personal information. Depending on your state of residence, you may have the right to request deletion of your personal information. We will respond to your request in the timeframe required under applicable law. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about how to exercise your rights, **please call the toll-free member phone number on your**

health plan ID card or you may contact a UnitedHealth Group Customer Call Center Representative at 1-800-457-8506 (TTY/RTT 711).

- **Submitting a Written Request.** To exercise any of your rights described above, mail your written requests to us at the following address:

  UnitedHealthcare

  Customer Service - Privacy Unit

  PO Box 740815

  Atlanta, GA 30374-0815

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

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

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

Financial Information Privacy Notice

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

Effective January 1, 2024

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

Information We Collect

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

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

Disclosure of Information

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

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

Confidentiality and Security

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

Questions About this Notice

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-800-457-8506 (TTY 711).**

---

[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc; OptumHealth Care Solutions, LLC; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holding, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra

Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. For a current list of entities subject to this notice go to www.uhc.com/privacy/entities-fn-v1

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

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

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

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

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

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

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

- **To know about all of your choices**. You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. 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. You can also contact Customer Service for assistance in locating an advanced directive form.
- **Fill it out and sign it**. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people**. You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

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

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

What if your instructions are not followed?

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

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

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

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

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

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

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

Is it about something else?

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

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

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

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

- You can **call Customer Service**.

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

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

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

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this **Evidence of Coverage** to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapters 5 and 6 give the details about your 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 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:
  - You must continue to pay your Medicare Part B premium to remain a member of the plan.
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.

- If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
- If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move outside of our plan service area, you cannot remain a member of our plan**.
- **If you move within our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

Chapter 9

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

Section 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

- Uses simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" 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 in Chapter 2, Section 3 of this document.

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

Coverage decisions and appeals

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

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

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

Asking for coverage decisions prior to receiving benefits

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

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

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

Making an appeal

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

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

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

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See Section 5.4 of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

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

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

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

There are 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 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"

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

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

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

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

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

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

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

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

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

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

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

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

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

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

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

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

For standard coverage decisions we use the standard deadlines.

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

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint". We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 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 information that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should **not** take extra days, you can file a "fast complaint." (See Section 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 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms	An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

A "fast appeal" is also called an **"expedited reconsideration."**

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

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

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

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

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

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

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

Deadlines for a "fast appeal"

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

Deadlines for a "standard appeal"

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your **health** condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should **not** take extra days, you can file a "fast complaint". When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 10 of this chapter for information on complaints.)
  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- If our plan says no to part or all of your appeal, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

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

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

Step 1: The independent review organization reviews your appeal.

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

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

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

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

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

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

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

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

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

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

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes.

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

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is **not** covered, or you did **not** follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

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

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

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

Section 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 6.1 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, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time. We also use the term "drug list" instead of "List of Covered Drugs" or "Formulary."

- If you 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 drugs is called a **"coverage determination."**

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

- Asking to cover a Part D drug that is not on the plan's **List of Covered Drugs. Ask for an exception. Section 6.2**
- 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 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

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 6.2 What is an exception?

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

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

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

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 3. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our **Drug List**. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our plan's Drug List is in one of 4 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
   - If our **Drug List** contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
   - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
   - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
   - You cannot ask us to change the cost-sharing tier for any drug in Tier 4 Specialty Tier.
   - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 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. If you ask us for a tiering exception, we will generally not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 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 generally give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must give you our answer **within 14 calendar days** after we 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 6.5 Step-by-step: How to make a Level 1 appeal

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

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

A "standard appeal" is usually made within 7 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 1-800-457-8506.** 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.
  - 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 6.6 explains the Level 2 appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard" appeal for a drug you 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.
  - 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 6.6 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 6.6 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 our plan says no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. 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." It is also

called “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 you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

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

- There are 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 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

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

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

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

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

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

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

Section 7.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

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

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

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

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with

Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge.**
  - If you meet this deadline, you may stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.
  - If you do **not** meet this deadline, and you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

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

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers”) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 7.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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

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

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

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

You can appeal to us instead

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

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

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

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

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

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

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

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

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

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

Step-by-Step: Level 2 alternate appeal process

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

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

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

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.

- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

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

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

Section 8.2 We will tell you in advance when your coverage will be ending

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

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

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

Section 8.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

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

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

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

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

How can you contact this organization?

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

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

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

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 8.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

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

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

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

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

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

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

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

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

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

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

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

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

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

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

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

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

Step-by-Step: Level 2 Alternate Appeal Process

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

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

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

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

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

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

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

- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 9 Taking your appeal to Level 3 and beyond

Section 9.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

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

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

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

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

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

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

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

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

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

Section 9.2 Appeal Levels 3, 4, and 5 for Part D Drug Requests

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

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

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

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

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

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

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

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

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

Making complaints

Section 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

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

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

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 us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: □You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. □You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. □You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. □You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 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 10.3 Step-by-step: Making a complaint

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

□**Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.

□**If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

□We must receive your complaint within 60 calendar days of the event or incident you are complaining about. If something kept you from filing your complaint (you were sick, we

provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days. We will address your complaint as quickly as possible but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.

If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. The address and fax numbers for filing complaints are located in Chapter 2 under "How to contact us when you are making a complaint about your medical care" or for Part D prescription drug complaints "How to contact us when you are making a complaint about your Part D prescription drugs."

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

Or

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

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about UnitedHealthcare® Group Medicare Advantage (HMO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Chapter 10

Ending your membership in the plan

Section 1 Introduction to ending your membership in our plan

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

- You might leave our plan because you have decided that you **want** to leave. Section 2 provides 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 4 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 and you will continue to pay your cost share until your membership ends.

In the event you choose to end your membership in our plan, re-enrollment may not be permitted, or you may have to wait until your plan sponsor's next Open Enrollment Period. You should consult with your plan sponsor regarding the availability of other coverage prior to ending your plan membership outside of your plan sponsor's Open Enrollment Period. It is important to understand your plan sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other retirement benefits before submitting your request to end your membership in our plan.

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

Section 2.1 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 your plan sponsor
- **Call Customer Service.**
- Find the information in the **Medicare & You 2024** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

Section 3 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

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

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**

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

Section 4 We must end your membership in the plan in certain situations

Section 4.1 When must we end your membership in the plan?

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

- We are notified that you no longer meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).
- Your former employer, union group or trust administrator's (plan sponsor's) contract with us is terminated.
- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than 6 months.
  - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan's area .
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you 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.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

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

Section 4.2 We cannot ask you to leave our plan for any health-related reason

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

What should you do if this happens?

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

Section 4.3 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 11

Legal notices

Section 1 Notice about governing law

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

Section 2 Notice about non-discrimination

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

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

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

Section 3 Notice about Medicare Secondary Payer subrogation rights

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

Section 4 Third party liability and subrogation

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

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

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

Section 5 Member liability

Note: This section only applies to you if you are required by your plan rules to obtain a referral before seeing non-network providers. Please see the chapter entitled **Using the plan's coverage for your medical services** to see if your plan requires referrals to non-network providers.

You will be liable if you receive services from non-network providers without authorization or a referral.

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

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

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

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

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

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

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

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

Section 8 Acts beyond our control

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

Section 9 Contracting medical providers and network hospitals are independent contractors

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

Section 10 Technology assessment

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

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

Section 11 Member statements

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

Section 12 Information upon request

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

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

Section 13 2024 Enrollee Fraud & Abuse Communication

2024 Enrollee Fraud & Abuse Communication

How you can fight healthcare fraud

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

Here are some examples of potential Medicare fraud cases:

- A health care provider - such as a physician, 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® Group Medicare Advantage (HMO) Customer Service at 1-800-457-8506 (TTY 711), 8 a.m.-8 p.m. local time, Monday-Friday.

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

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

Section 14 Commitment of Coverage Decisions

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

Section 15 Renew Active® Terms and Conditions

Eligibility requirements

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

Enrollment requirements

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

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

Liability waiver

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

Other requirements

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

Data requirements

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

Chapter 12

Definitions of important words

Chapter 12

Definitions of important words

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

Annual Enrollment Period –The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or 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.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of UnitedHealthcare® Group Medicare Advantage (HMO), you only have to pay our plan's allowed cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods. For Inpatient Hospital Care, Medicare-defined hospital benefit periods do not apply. For inpatient hospital care, the cost-sharing described in the Medical Benefits Chart in Chapter 4 applies each time you are admitted to the hospital. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers

Medicare.

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

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

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.

Coinsurance for in-network services is based upon contractually negotiated rates (when available for the specific covered service to which the coinsurance applies) or Medicare Allowable Cost, depending on our contractual arrangements for the service.

Compendia – Medicare-recognized reference books for drug information and medically accepted indications for Part D coverage.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you 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.

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.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 4 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by 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 in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

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.

Daily Cost Share applies only if the drug is in the form of a solid oral dose (e.g., tablet or capsule) when dispensed for less than a one-month supply under applicable law. The Daily Cost Share requirements do not apply to either of the following:

1. Solid oral doses of antibiotics.
2. Solid oral doses that are dispensed in their original container or are usually dispensed in their original packaging to assist patients with compliance.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require

immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering 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.

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

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Chapter 4, Section 2.1 under the heading "Home health agency care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a

hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day/7 days a week. Note: If you are not entitled to Medicare Part A coverage, hospice services are not covered by Medicare or the plan.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $5,030.

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.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the plan year for covered Part A and Part B services. Amounts you or your plan sponsor pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

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

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 (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B

benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Allowable Cost – The maximum price of a service for reimbursement purposes under Original Medicare.

Medicare Assignment – In Original Medicare, a doctor or supplier "accepts assignment" when he or she agrees to accept the Medicare-approved amount as full payment for covered services.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 1, Section 3.2)

Network 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."

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network 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 coordinate or provide covered services to members of our plan.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service.

Part C – 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 as covered Part D drugs 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.

Plan Sponsor – Your former employer, union group or trust administrator.

Plan Year – The period of time your plan sponsor has contracted with us to provide covered services and covered drugs to you through the plan. Your plan sponsor's plan year is listed inside the front cover of the Evidence of Coverage.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health

problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – For medical services it means a process where your PCP or treating provider must receive approval in advance before certain medical services will be provided or payable. For certain drugs it means a process where you or your provider must receive approval in advance before certain drugs will be provided or payable. 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 are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Provider – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

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

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.

Real-Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A formal recommendation by your Primary Care Provider (PCP) for you to receive care from a specialist or network provider.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Retail Walk-In Clinic – A provider location that generally does not require appointments and may be a standalone location or located in a retail store, supermarket or pharmacy. Walk-In Clinic Services are subject to the same cost-sharing as Urgent Care Centers. (See the Benefit Chart in Chapter 4)

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription

drug costs, if you move into a nursing home, or if we violate our contract with you.

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® Group Medicare Advantage (HMO) Customer Service:

Call **1-800-457-8506**

Calls to this number are free. 8 a.m.-8 p.m. local time, Monday-Friday. Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**

Calls to this number are free. 8 a.m.-8 p.m. local time, Monday-Friday.

Write: **P.O. Box 30770**
Salt Lake City, UT 84130-0770

retiree.uhc.com

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.
You can call the SHIP in your state at the number listed in Chapter 2 Section 3 of the Evidence of Coverage.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

UHEX24HM0111381_004