Enrollee Handbook 2024

UHC Dual Choice DC-S001 (PPO D-SNP)

Toll-free **1-866-242-7726**, TTY **711**
8:00 a.m.–8:00 p.m., 7 days a week, October–March;
8:00 a.m.–5:30 p.m., Monday–Friday, April–September

myuhc.com/CommunityPlan

United Healthcare®

Y0066_EOC_H2406_053_000_2024_C

January 1–December 31, 2024

Enrollee Handbook

Your Medicare & District Medicaid Health and Drug Coverage under UHC Dual Choice DC-S001 (PPO D-SNP)

Thank you for choosing UnitedHealthcare Community Plan. UnitedHealthcare Community Plan operates the District Dual Choice Program. UHC Dual Choice DC-S001 (PPO D-SNP) program provides both Medicaid and Medicare covered benefits.

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

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan. 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.

UnitedHealthcare Community Plan is a specialized Medicare Advantage Plan (a Medicare "Special Needs Plan"), which means its benefits are designed for people with special health care needs.

This plan is designed for people who have Medicare and who are also entitled to assistance from Medicaid.

The UnitedHealthcare Community Plan is a private company. This plan is approved by Medicare.

The plan is also approved by the District to cover your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage.

UnitedHealthcare Community Plan supports the District of Columbia's goals of increased access, improved health outcomes and reduced costs by offering Medicaid benefits to the following enrollees under the program:

- **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-sharing and are also eligible for full Medicaid benefits. Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance, and copayment amounts for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).
- **Full Benefits Dual Eligible (FBDE):** Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. Your cost share is 0% when the service is covered by both Medicare and Medicaid.

OMB Approval 0938-1444 (Expires: June 30, 2026)

Enrollee Handbook Introduction

This Enrollee Handbook, otherwise known as the Evidence of Coverage, tells you about your coverage under our plan through December 31, 2024. It explains health care services and prescription drug coverage. Key terms and their definitions appear in alphabetical order in **Chapter 12** of your **Enrollee Handbook**.

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

When this **Enrollee Handbook** says “we”, “us”, “our”, or “our plan”, it means UHC Dual Choice DC-S001 (PPO D-SNP).

This document is available for free in Spanish and Amharic.

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

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at **1-877-266-4832**, TTY **711**. Someone that speaks your language can help you. This is a free service.

OMB Approval 0938-1444 (Expires: June 30, 2026)

UnitedHealthcare Community Plan does not treat enrollees differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call **1-866-242-7726**, TTY **711**, between 8:00 a.m.–5:30 p.m. EST, Monday–Friday, months April–September; 8:00 a.m.–8:00 p.m. EST, 7 days a week, months October–March.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://hhs.gov/ocr/complaints/index.html

Phone:
Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail:
U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

UnitedHealthcare Community Plan can provide free services to help you communicate with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English including qualified language interpreters and information written in other languages

To ask for help, please call **1-866-242-7726**, TTY **711**, between 8:00 a.m.–5:30 p.m. EST, Monday–Friday, months April–September; 8:00 a.m.–8:00 p.m. EST, 7 days a week, months October–March.

If you need any other assistance, please contact the Office of Health Care Ombudsman at **1-202-724-7491**.

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English

If you do not speak and/or read English, please call **1-866-242-7726**, TTY **711**, between 8:00 a.m.–5:30 p.m. EST, Monday–Friday, months April–September; 8:00 a.m.–8:00 p.m. EST, 7 days a week, months October–March. A representative will assist you.

Spanish

Si no habla ni lee en inglés, llame al **1-866-242-7726**, TTY **711**, de lunes a viernes, de 8:00 a.m. a 5:30 p.m. hora del este, de abril a septiembre; y los 7 días de la semana, de 8:00 a.m. a 8:00 p.m., hora del este, de octubre a marzo. Un representante le brindará asistencia.

Amharic

እንግሊዘኛ የማይናገሩ እና/ወይም የማያነቡ ከሆነ፣ እባክዎን በ1-866-242-7726፣ TTY 711፣ ከቀኑ 8፡00am - 5፡30pm EST፣ ከሰኞ - አርብ፣ ወራት ከኤፕሪል - ሴፕቴምበር፣ 8:00am - 8:00pm EST፣ በሳምንት 7 ቀናት፣ ወራት ከአክቶበር - ማርች። አንድ ተወካይ ይረዳዎታል።

Vietnamese

Nếu quý vị không nói và/hoặc đọc được tiếng Anh, vui lòng gọi đến số 1-866-242-7726, TTY (Thoại văn bản) 711, từ 8:00 sa – 5:30 ch, giờ Chuẩn Miền Đông (EST), từ thứ Hai – thứ Sáu trong tháng Tư – tháng Chín; 8:00 sa – 8:00 tối, giờ Chuẩn Miền Đông (EST), 7 ngày một tuần trong tháng Mười – tháng Ba. Một nhân viên sẽ hỗ trợ cho quý vị.

Korean

영어로 말하거나 읽지 못하시는 경우, 4월~9월에는 월요일~금요일 오전 8시~오후 5시 30분(동부 표준시), 10월~3월에는 주 7일 오전 8시~오후 8시(동부 표준시)에 1-866-242-7726, TTY 711로 전화하십시오. 담당자가 도움을 드릴 것입니다.

French

Si vous ne savez pas parler et/ou lire l’anglais, veuillez composer le numéro 1-866-242-7726, téléscripteur 711, de 8:00 à 17:30 (heure normale de l’Est), du lundi au vendredi, d’avril à septembre ; de 8:00 à 20:00 (heure normale de l’Est), 7 jours sur 7, d’octobre à mars. Un représentant vous aidera.

Arabic

إذا كنت لا تتحدث الإنجليزية و/أو لا تجيد قراءتها، فيُرجى الاتصال على 1-866-242-7726، الهاتف النصي 711، بين 8:00 صباحًا و5:30 مساءً بتوقيت شرق الولايات المتحدة، من الإثنين إلى الجمعة، من أبريل إلى سبتمبر؛ ومن 8:00 صباحًا إلى 8:00 مساءً بتوقيت شرق الولايات المتحدة، 7 أيام في الأسبوع، من أكتوبر إلى مارس. وسيُساعدك أحد ممثلي الخدمة.

Mandarin

如果您不会说和/或阅读英语，请在四月至九月之间，于周一至周五，上午 8:00 至下午 5:30（美国东部标准时间）；在十月至三月之间，每周 7 天，上午 8:00 至晚上 8:00（美国东部标准时间），致电 1-866-242-7726，听障专线 (TTY) 711。一位代表将为您提供帮助。

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Russian
Если вы не говорите и/или не читаете по-английски, позвоните по телефону 1-866-242-7726, TTY 711, 08:00 – 17:30 по восточному поясному времени, с понедельника по пятницу, с апреля по сентябрь; 08:00 – 20:00 по восточному поясному времени, 7 дней в неделю, с октября по март. Наш представитель поможет Вам.

Burmese
သင်အင်္ဂလိပ်စကား မပြောလျှင် နှင့်/သို့မဟုတ် အင်္ဂလိပ်ဘာသာစကားကို မဖတ်တတ်လျှင်၊ ဖုံးလွှမ်း စက်တင်ဘာလအတွင်းဖြစ်ပါက၊ တနင်္လာနေ့မှ သောကြာနေ့၊ အရှေ့ပိုင်းစံတော်ချိန် နံနက် 8:00 နာရီမှ ညနေ 5:30 အတွင်းနှင့် အောက်တိုဘာလမှ မတ်လအတွင်းဖြစ်ပါက၊ တစ်ပတ်လျှင် 7 ရက်လုံး၊ အရှေ့ပိုင်းစံတော်ချိန်၊ နံနက် 8:00 နာရီမှ ည 8:00 နာရီအတွင်း 1-866-242-7726၊ TTY 711 ကို ဖုန်းခေါ်ဆိုပါ။ ကိုယ်စားလှယ်တစ်ဦးက သင့်အား အကူအညီပေးသွားပါမည်။

Cantonese
如果您不會說和/或閱讀英語，請在美國東部標準時間週一至週五、四月至九月的上午 8:00 至下午 5:30 之間致電 1-866-242-7726，聽障專綫（TTY）711；美國東部標準時間上午 8:00 至晚上 8:00，每週 7 天，十月至三月。代表將為您提供協助。

Farsi
اگر به زبان انگلیسی صحبت نمی‌کنید و یا متن نمی‌خوانید، لطفاً از ساعت 8:00 صبح تا 5:30 عصر EST، از دوشنبه تا جمعه، ماههای آوریل تا سپتامبر؛ 8:00 صبح تا 8:00 شب EST،7 روز هفته، ماههای اکتبر تا مارس با 1-866-242-7726، TTY 711 تماس بگیرید. یکی از نمایندگان به شما کمک خواهد کرد.

Polish
Jeśli nie mówisz i/lub nie czytasz po angielsku, prosimy o kontakt pod numerem 1-866-242-7726, TTY 711, w godzinach 8:00 – 7:30 EST, od poniedziałku do piątku, w miesiącach kwiecień – wrzesień; 8:00 – 20:00 EST, 7 dni w tygodniu, w miesiącach październik – marzec. Przedstawiciel firmy udzieli Ci pomocy.

Portuguese
Se não fala e/ou não lê inglês, ligue para o 1-866-242-7726, TTY 711, entre as 8:00h - 17:30h EST, de segunda a sexta-feira, nos meses de abril - setembro; 8:00h - 20:00h EST, 7 dias por semana, nos meses de outubro – março. Um representante irá ajudá-lo(a).

Punjabi
ਜੇ ਤੁਸੀਂ ਅੰਗਰੇਜ਼ੀ ਨਹੀਂ ਬੋਲਦੇ ਅਤੇ/ਜਾਂ ਨਹੀਂ ਪੜ੍ਹਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-866-242-7726, TTY 711 ਨੂੰ, ਅਪ੍ਰੈਲ - ਸਤੰਬਰ ਮਹੀਨੇ ਲਈ ਸੋਮਵਾਰ - ਸ਼ੁੱਕਰਵਾਰ, ਸਵੇਰੇ 8:00 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 5:30 ਵਜੇ EST; ਅਕਤੂਬਰ – ਮਾਰਚ ਮਹੀਨੇ ਲਈ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ ਸਵੇਰੇ 8:00 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8:00 ਵਜੇ EST ਦੇ ਵਿਚਕਾਰ ਕਾਲ ਕਰੋ। ਇੱਕ ਪ੍ਰਤੀਨਿਧੀ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰੇਗਾ।

Haitian Creole
Si ou pa pale ak/oswa li anglè, tanpri rele 1-866-242-7726, TTY 711, ant 8:00am – 5:30pm EST, lendi – vandredi, pou mwa avril – septanm; 8:00am – 8:00pm EST, 7 jou nan yon semèn, pou mwa oktòb – mas. Yon reprezantan pral ede ou.

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Hindi
यदि आप अंग्रेज़ी बोल और/या पढ़ नहीं पाते हैं, तो कृपया 1-866-242-7726, TTY 711 पर, सुबह 8:00 – शाम 5:30 EST, सोमवार – शुक्रवार, महीने अप्रैल – सितम्बर; सुबह 8:00 – शाम 8:00 EST, 7 दिन प्रति सप्ताह, महीने अक्टूबर – मार्च संपर्क करें। एक प्रतिनिधि आपकी सहायता करेगा।

Somali
Haddii aadan ku hadlin iyo/ama akhrin Ingiriisi, fadlan wac 1-866-242-7726, TTY 711, inta u dhexaysa 8:00 subaxnimo – 5:30 galabnimo EST, Isniinta – Jimcaha, billaha Abriil – Sitembar; 8:00 subaxnimo – 8:00 galabnimo EST, 7 maalin isbuucii, billaha Oktoobar – Maarso. Wakiil ayaa ku caawin doona.

Hmong
Yog koj hais lus As Kiv tsis tau thiab/los sis nyeem ntawv As Kiv tsis tau, ces hu rau 1-866-242-7726, TTY 711, thaj tsam thaum 8:00 teev sawv ntxov – 5:30 teev yav tsaus ntuj EST, hnub Monday – Friday, lub Plaub Hlis Ntuj – Cuaj Hli Ntuj; 8:00 teev sawv ntxov – 8:00 teev tsaus ntuj EST, 7 hnub hauv ib lub vij, Lub Kaum Hli Ntuj – Peb Hlis Ntuj. Ib tug neeg sawv cev yuav los pab koj.

Italian
Se non si parla e/o legge in lingua inglese, si prega di chiamare il numero +1 866 242 7726, TTY 711, dalle 8:00 alle 17:30 ora standard orientale, da lunedì a venerdì, nei mesi da aprile a settembre; e dalle 8:00 alle 20:00 ora standard orientale, 7 giorni su 7, nei mesi da ottobre a marzo. Si riceverà assistenza da un rappresentante.

Tagalog
Kung hindi ka nagsasalita at/o nagbabasa ng English, pakitawagan ang 1-866-242-7726, TTY 711, sa pagitan ng 8:00am – 5:30pm EST, Lunes – Biyernes, mga buwan ng Abril – Setyembre; 8:00am – 8:00pm EST, 7 araw sa isang linggo, mga buwan ng Okttubre – Marso. Tutulungan ka ng isang kinatawan.

Japanese
英語を話したり読んだりできない場合は、以下の時間帯に電話（1-866-242-7726、TTY 711）でお問合せください。4月～9月、午前8:00～午後5:30（東部標準時）、月曜日～金曜日。10月～3月、午前8:00～午後8:00（東部標準時）、週7日間。担当者がお手伝いいたします。

2024 Enrollee Handbook
Table of Contents

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

If you have questions, please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free. For more information, visit **myuhc.com/CommunityPlan**.

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? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free.
For more information, visit **myuhc.com/CommunityPlan**.

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Disclaimers

- Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the District Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare and District Medicaid.
- Coverage under UHC Dual Choice DC-S001 (PPO D-SNP) is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at **irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information on the individual shared responsibility requirement.

Chapter 1

Getting started as an enrollee

Chapter 1

Getting started as an enrollee

Introduction

This chapter includes information about UHC Dual Choice DC-S001 (PPO D-SNP), a health plan that coordinates all of your Medicare and DC Medicaid services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your **Enrollee Handbook**.

If you have questions, please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free. For more information, visit **myuhc.com/CommunityPlan**.

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Section A Welcome to our plan

Our plan provides Medicare and DC Medicaid services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.

Section B Information about Medicare and DC Medicaid

Section B1 Medicare

Medicare is the federal health insurance program for:

- People 65 years of age or over,
- Some people under age 65 with certain disabilities, **and**
- People with end-stage renal disease (kidney failure).

Section B2 DC Medicaid

DC Medicaid is the name of the District of Columbia's (the District's) Medicaid program. DC Medicaid is run by the District and is paid for by the District and the federal government. DC Medicaid helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state or the District decides:

- What counts as income and resources,
- Who is eligible,
- What services are covered, **and**
- The cost for services.

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

Medicare and the District approved our plan. You can get Medicare and DC Medicaid services through our plan as long as:

- We choose to offer the plan, **and**

- Medicare and the District allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and DC Medicaid services is not affected.

Section C Advantages of our plan

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

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
  - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

Section D Our plan's service area

Only people who live in our service area can join our plan. To remain an enrollee of this plan, you must reside within the District of Columbia.

You cannot stay in our plan if you move outside of our service area. Refer to **Chapter 9** of your **Enrollee Handbook** for more information about the effects of moving out of our service area.

If you plan to move out of the service area, you cannot remain an enrollee of this plan. Please contact Enrollee Services number at **1-866-242-7726**, TTY **711**, 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.

Section E What makes you eligible to be a plan enrollee

You are eligible for our plan as long as you:

- Live in our service area (incarcerated individuals are not considered living in the service area even if they are physically located in it), **and**
- Have Medicare Part A and Medicare Part B, **and**
- Are a United States citizen or are lawfully present in the United States, **and**
- Are currently eligible for DC Medicaid, **and**
- You are at least 21 years old

If you lose eligibility but can be expected to regain it within 6 months, then you are still eligible for our plan.

Call Enrollee Services for more information.

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

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

Section G Your care team and care plan

Section G1 Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care coordinator, or other health person that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

Section G2 Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and LTSS or other services.

Your care plan includes:

- Your health care goals, **and**
- A timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

Section H Your monthly costs for UHC Dual Choice DC-S001 (PPO D-SNP)

Your costs may include the following:

- Plan premium (Section H1)
- Monthly Medicare Part B Premium (Section H2)
- Part D Late Enrollment Penalty (Section H3)
- Income Related Monthly Adjusted Amount (Section H4)

In some situations, your plan premium could be less.

The "Extra Help" program helps people with limited resources pay for their drugs. **Chapter 2**, Section H2 tells more about this program. If you qualify, enrolling in the program might lower your monthly plan premium.

If you **already enrolled** and are getting help from one of these programs, **the information about premiums in this Enrollee Handbook 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 Enrollee Services and ask for the "LIS Rider".

Section H1 Plan premium

As an enrollee of our plan, you pay a monthly plan premium unless you qualify for “Extra Help” with your prescription drug costs. You will not pay a monthly Plan premium (prescription drug plan premium) if you qualify for “Extra Help”. People with Medicare and Medicaid automatically qualify for “Extra Help”. Because you qualify for "Extra Help", for 2024 the monthly premium for our plan is $0.

Section H2 Monthly Medicare Part B premium

Many enrollees are required to pay other Medicare premiums

Some enrollees are required to pay other Medicare premiums. As explained in Section E above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most UHC Dual Choice DC-S001 (PPO D-SNP) enrollees, Medicaid pays for your Medicare Part A premium (if you don’t qualify for it automatically) and for your Medicare Part B premium.

If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain an enrollee of the plan. This includes your premium for Medicare Part B. It may also include a premium for Medicare Part A which affects enrollees who aren’t eligible for premium free Medicare Part A. **In addition, please contact Enrollee Services or your care coordinator and inform them of this change.**

Section H3 Part D Late Enrollment Penalty

Because you are dual-eligible, the LEP doesn't apply as long as you maintain your dual-eligible status, but if you lose status you may incur LEP. Some enrollees 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. When you first enroll in our plan, we let you know the amount of the penalty.

You will not have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free. For more information, visit **myuhc.com/CommunityPlan**.

- 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 2023, this average premium amount is $32.74.
- 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 $32.74, which equals $4.58. This rounds to $4.60. This amount would be added to the 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 H4 Income Related Monthly Adjustment Amount

Some enrollees are 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/monthlypremium-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 I Your Enrollee Handbook

Your **Enrollee Handbook** is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your **Enrollee Handbook** or call **1-800-MEDICARE (1-800-633-4227).**

You can ask for a **Enrollee Handbook** by calling Enrollee Services at the numbers at the bottom of the page. You can also refer to the **Enrollee Handbook** found on our website at the web address at the bottom of the page.

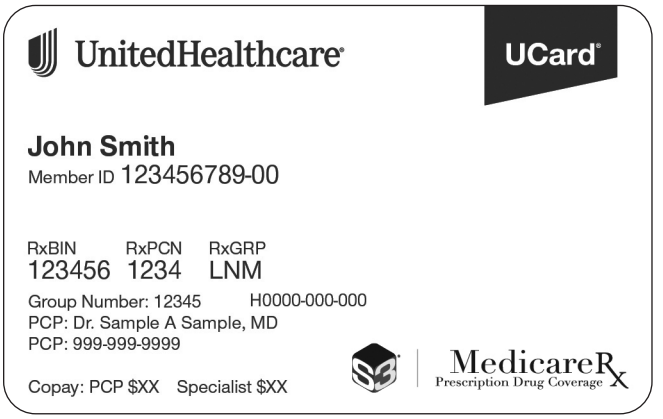
The contract is in effect for the months you are enrolled in our plan between January 1, 2024 and December 31, 2024.

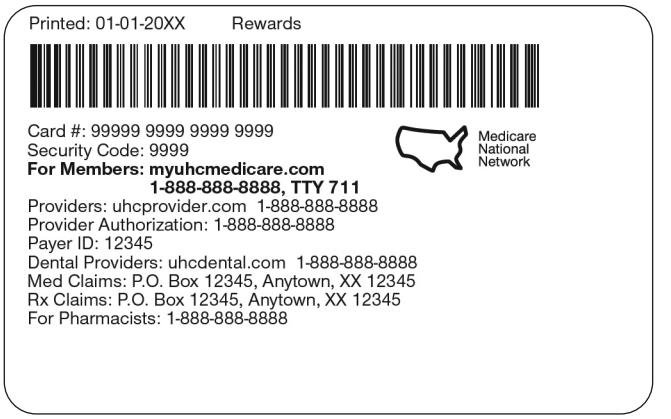
Section J Other important information you get from us

Other important information we provide to you includes your enrollee UCard®, information about how to access a **Provider and Pharmacy Directory** and information about how to access a **List of Covered Drugs**, also known as a Formulary.

Section J1 Your UnitedHealthcare enrollee UCard

Under our plan, you have one card for your Medicare and DC Medicaid services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Your United Healthcare enrollee UCard® can be used to purchase healthy foods, over-the-counter (OTC) items, and to pay your utilities. Here is a sample enrollee UCard:





If your enrollee UCard is damaged, lost, or stolen, call Enrollee Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are an enrollee of our plan, you do not need to use your red, white, and blue Medicare card or your DC Medicaid card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your enrollee UCard, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your **Enrollee Handbook** to find out what to do if you get a bill from a provider.

Your enrollee UCard can be used to purchase healthy foods, over-the-counter (OTC) items, and to pay your utilities. Benefits, features and/or devices vary by plan/area. Limitations, exclusions and/or network restrictions may apply. Food, OTC and utility benefits have expiration time frames. Call your plan or review your **Enrollee Handbook** for more information.

Section J2 Provider and Pharmacy Directory

The **Provider and Pharmacy Directory** lists the providers and pharmacies in our plan's network. While you're an enrollee of our plan, you must use network providers to get covered services.

You can ask for a **Provider and Pharmacy Directory** (electronically or in hard copy form) by calling Enrollee Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the **Provider and Pharmacy Directory** at the web address at the bottom of the page.

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free.
For more information, visit **myuhc.com/CommunityPlan**.

Definition of network providers

- Our network providers include:
  - Doctors, nurses, and other health care professionals that you can use as an enrollee of our plan;
  - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

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

Definition of network pharmacies

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

Call Enrollee Services at the numbers at the bottom of the page for more information. Both Enrollee Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

Section J3 List of Covered Drugs

The plan has a **List of Covered Drugs**. We call it the "Drug List" for short. It tells you which prescription drugs our plan covers.

The "Drug List" also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your **Enrollee Handbook** for more information.

Each year, we send you the "Drug List," but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Enrollee Services or visit our website at the address at the bottom of the page.

Section J4 The Explanation of Benefits

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription

drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take. **Chapter 6** of your **Enrollee Handbook** gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Enrollee Services at the numbers at the bottom of the page.

Section K Keeping your membership record up to date

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

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you.**

Tell us right away about the following:

- Changes to your name, your address, or your phone number;
- Changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- Any liability claims, such as claims from an automobile accident;
- Admission to a nursing facility or hospital;
- Care from a hospital or emergency room;
- Changes in your caregiver (or anyone responsible for you); **and**
- You take part in a clinical research study. (**Note**: You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Enrollee Services at the numbers at the bottom of the page.

District residents can keep their information up to date with DC Medicaid online at **districtdirect.dc.gov** or through the Public Benefits Call Center at **1-202-727-5355**.

Section K1 Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your **Enrollee Handbook**.

Section L 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 Enrollee Services. You may need to give your plan enrollee ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

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

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

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)

- Black lung benefits
- Workers' Compensation

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

Chapter 2

Important phone numbers and resources

Chapter 2

Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your **Enrollee Handbook**.

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free.
For more information, visit **myuhc.com/CommunityPlan**.

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Section A Enrollee Services

Method	Contact information
Call	**1-866-242-7726** This call is free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September We have free interpreter services for people who do not speak English.
TTY	**711.** This call is free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September
Fax	**1-888-950-1169**
Write	United Healthcare Attention: Enrollee Services Department P.O. Box 30769 Salt Lake City, UT 84130-0769
Website	**myuhc.com/CommunityPlan**

Contact Enrollee Services to get help with:

- Questions about the plan
- Questions about claims or billing
- Coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - Your benefits and covered services **or**
    - The amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of your **Enrollee Handbook**.
- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free. For more information, visit **myuhc.com/CommunityPlan**.

– To learn more about making an appeal, refer to **Chapter 9** of your **Enrollee Handbook** or contact Enrollee Services.

Method	Appeals for medical care – Contact information
Call	**1-866-242-7726** Calls to this number are free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September
TTY	**711** Calls to this number are free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September
Write	United Healthcare Appeal and Grievance Department Attn: Complaint and Appeals Department P.O. Box 6106, MS CA 124-0187 Cypress, CA 90630-0016
Fax	Standard **1-888-517-7113** Expedited **1-866-373-1081**

- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).
  - You can call us and explain your complaint at **1-866-242-7726**, TTY **711**.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at **medicare.gov/MedicareComplaintForm/home.aspx**. Or you can call **1-800-MEDICARE (1-800-633-4227)** to ask for help.

- You can also contact DC Medicaid with your complaint by contacting Dual Choice support at **1-202-442-9533**, TTY **711**, Monday–Friday, 9 a.m.–4:45 p.m.
- To learn more about making a complaint about your health care, refer to **Chapter 9** of your **Enrollee Handbook**.

• Coverage decisions about your drugs

- A coverage decision about your drugs is a decision about:
  - Your benefits and covered drugs **or**
  - The amount we pay for your drugs.
- This applies to your Medicare Part D drugs and DC Medicaid prescription drugs and over-the-counter drugs.
- For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your **Enrollee Handbook**.

• Appeals about your drugs

- An appeal is a way to ask us to change a coverage decision.
- For more on making an appeal about your prescription drugs, refer to **Chapter 9** of your **Enrollee Handbook**.

Method	Appeals for prescription drugs – Contact information
Call	**1-866-242-7726** Calls to this number are free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September Expedited **1-855-409-7041**
TTY	**711** Calls to this number are free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September
Write	United Healthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA 124-0197 Cypress, CA 90630-0016
Fax	Standard **1-866-308-6294** Expedited **1-866-308-6296**

- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan to Medicare. You can use an online form at **medicare.gov/MedicareComplaintForm/home.aspx**. Or you can call **1-800-MEDICARE (1-800-633-4227)** to ask for help.
  - For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your **Enrollee Handbook**.
- Payment for health care or drugs you already paid for

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free.
For more information, visit **myuhc.com/CommunityPlan**.

- For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of your **Enrollee Handbook**.
- If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your **Enrollee Handbook**.

Section B Your Care Management Team

Method	Contact information
Call	**1-866-242-7726** This call is free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September
Fax	**1-888-950-1169**
Write	United Healthcare Attention: Enrollee Services Department P.O. Box 30769 Salt Lake City, UT 84130-0769
Website	**myuhc.com/CommunityPlan**

Contact your care management team to get help with:

- Questions about your health care
- Questions about getting behavioral health (mental health and substance use disorder) services
- Questions about transportation

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free. For more information, visit **myuhc.com/CommunityPlan**.

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Section C DC State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In the District, the SHIP is called the DC State Health Insurance Assistance Program (SHIP).

The DC SHIP is not connected with any insurance company or health plan.

Method	Contact information
Call	**1-202-727-8370** Monday to Friday, 9:30 a.m.–4:30 p.m.
TTY	**711** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Write	Department of Aging and Community Living 250 E Street SW Washington, DC 20024
Email	**dacl@dc.gov**
Website	**dacl.dc.gov/service/health-insurance-counseling**

Contact the DC SHIP for help with:

- Questions about Medicare
- DC SHIP counselors can answer your questions about changing to a new plan and help you:
  - Understand your rights,
  - Understand your plan choices,
  - Make complaints about your health care or treatment, **and**
  - Straighten out problems with your bills.

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free. For more information, visit **myuhc.com/CommunityPlan**.

Section D Quality Improvement Organization (QIO)

The District has an organization called Livanta BFCC-QIO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta BFCC-QIO is not connected with our plan.

Method	Contact information
Call	**1-888-396-4646** Monday to Friday, 9 a.m.–5 p.m.; weekends and holidays, 11 a.m.–3 p.m.
TTY	**1-888-985-2660** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Write	Livanta BFCC-QIO Program 10820 Guilford Rd, STE 202 Annapolis Junction, MD 20701
Website	**livantaqio.com**

Contact Livanta BFCC-QIO for help with:

- Questions about your health care rights
- Making a complaint about the care you got if you:
  - Have a problem with the quality of care,
  - Think your hospital stay is ending too soon, **or**
  - Think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

Section E Medicare

Medicare is the federal health insurance program for people 65 years of age or over, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

Method	Contact information
Call	**1-800-MEDICARE (1-800-633-4227)** Calls to this number are free, 24 hours a day, 7 days a week.
TTY	**1-877-486-2048.** This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.

Method	Contact information
Website	**medicare.gov** This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has documents you can print right from your computer. 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. These tools provide an **estimate** of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about UHC Dual Choice DC-S001 (PPO D-SNP): • Tell Medicare about your complaint: You can submit a complaint about UHC Dual Choice DC-S001 (PPO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to **medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you.

Section F DC Medicaid

Medicaid is a joint federal and District government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Some people are eligible for Medicaid but not Medicare. In the District of Columbia, Medicaid may pay for personal care, homemaker and other services that are not covered by Medicare. Medicaid also has programs that can help pay for your Medicare premiums and other costs if you are eligible for Medicare and qualify. If you have questions about the assistance you get from Medicaid, contact Dual Choice Support at **1-202-442-9533**, TTY **711**, Monday–Friday, 9 a.m.–4:45 pm.

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

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

Method	Contact information
Call	**1-202-442-9533** Monday–Friday, 9 a.m.–4:45 p.m.
TTY	**711** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Write	DC Department of Health Care Finance 441 4th ST NW, 900S Washington, DC 20001
Email	**DualChoice@dc.gov**
Website	**dhcf.dc.gov/**

Section G Office of Health Care Ombudsman and Bill of Rights

The Office of Health Care Ombudsman and Bill of Rights works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Office of Health Care Ombudsman and Bill of Rights also helps you with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

Method	Contact information
Call	**1-202-724-7491** 9 a.m.–4:45 p.m. local time, Monday–Friday
TTY	**711** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Write	Office of the Health Care Ombudsman and Bill of Rights Department of Health Care Finance 441 4th Street, NW, Suite 250 North Washington, DC 20001
Email	**healthcareombudsman@dc.gov**
Website	**healthcareombudsman.dc.gov**

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free. For more information, visit **myuhc.com/CommunityPlan**.

Section H The Office of the DC Long-Term Care Ombudsman

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

The Office of the DC Long-Term Care Ombudsman is not connected with our plan or any insurance company or health plan.

Method	Contact information
Call	**1-202-434-2190** Calls are responded to within 24 hours or the next business day
Write	DC LTC Ombudsman Program AARP Legal Counsel for the Elderly 601 E Street, NW Washington, DC 20049
Email	**DCOmbuds@aarp.org**
Website	**aarp.org/legal-counsel-for-elderly/what-we-do/info-2017/dc-longterm-care-ombudsman**

Section I Programs to Help People Pay for Their Prescription Drugs

The **Medicare.gov** website (**medicare.gov/drug-coverage-part-d/costs-for-medicare-drugcoverage/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, as described below.

Section I1 Extra Help

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

Method	Contact information
Call	**1-800-MEDICARE (1-800-633-4227)** Calls to this number are free, 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Website	**medicare.gov**

Section I2 AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance. For information about enrolling in DC ADAP and a list of drugs available through the program, please visit **dchealth.dc.gov/DC-ADAP**. **Note:** To be eligible for the ADAP operating in the District, individuals must meet certain criteria, including proof of the District residence and HIV status, low income as defined by the District, 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 **1-202-671-4815**, TTY **711**.

Section J Social Security

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

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

Method	Contact information
Call	**1-800-772-1213** Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Website	**ssa.gov**

Section K Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive Medicare through the RRB, 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 RRB, contact the agency.

Method	Contact information
Call	**1-877-772-5772** Calls to this number are free. If you press "0", you may speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. If you press "1", you may access the automated RRB Help Line and recorded information 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number are **not** free.
Website	**rrb.gov**

Section L Group insurance or other insurance from an employer

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

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

Chapter 3

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

Chapter 3

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

Introduction

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

Section A Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of your **Enrollee Handbook**. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of your **Enrollee Handbook**.

Providers are doctors, nurses, and other people who give you services and care. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

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

Section B Rules for getting services our plan covers

Our plan covers all services covered by Medicare and DC Medicaid. This includes behavioral health and LTSS.

Our plan will generally pay for health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be a **plan benefit**. This means we include it in our Medical Benefits Chart in **Chapter 4** of your **Enrollee Handbook**.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another doctor. As a plan enrollee, you must choose a network provider to be your PCP.
  - In most cases, our plan must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services. To learn more about referrals, refer to page **11-11**.
  - You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, refer to section D1 in this chapter).

- **You must get your care from network providers.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you will have to pay the provider in full for the services provided. Here are some cases when this rule does not apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to **Section H** in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. You must get approval from us before you start receiving care from an out-of-network provider. Contact your care navigator by calling Enrollee Services at toll-free **1-866-242-7726**. In this situation, we cover the care as if you got it from a network provider.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility. The cost-sharing you pay 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 an out-of-network provider the cost-sharing for the dialysis may be higher.
  - You can go to a family planning provider of your choice even if they are out-of-network. No prior authorization is required.
  - We cover post-stabilization services if you have an emergency medical condition, regardless of whether the provider is in or out of the network.

Section C Your care management team

The care management team are people to help you (the enrollee) use your benefits to get the care and services you need. This includes helping you get additional benefits through your health plan that you may not have been able to get before joining UHC Dual Choice DC-S001 (PPO D-SNP). The care navigator will work with you to make sure your health plan knows what you need and how you want to get your services, and will help you with questions you have about getting care. Your care navigator can also help connect you with community resources. Working with you and your care team, your care navigator will help you make an Individualized Care Plan (ICP) that will be updated if your needs and preferences change over time.

Section C1 What a care navigator is

Navigators provide both inbound and outbound support calls to our enrollees. Navigators provide one-on-one support for enrollees in several ways:

- A single point of contact for enrollee assistance.
- A familiar and consistent partner for the enrollee.
- Help to address and resolve the enrolllees' healthcare and enrollees services questions.
- Support for the enrollees' caregivers, to make them an integral part of the enrollee experience, including answering questions and advocating for care and social support.
- A tailored experience which may include:
  - Coordination of care.
  - Resolution of claims issues.
  - Support for appeals and grievances.
  - Addressing social support needs (e.g., transportation, housing).
  - Explain available resources and benefits.
  - Assist with Social Determinants of Health (SDOH).
  - Assist with locating providers and with appointment scheduling.
  - Promoting and scheduling Wellness Visits to PCPs.

Section C2 How you can contact your care navigator

If you wish to speak to a Care Navigator, you may call Enrollee Services at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, Oct–Mar; 8:00 a.m.–5:30 p.m., Monday–Friday, Apr–Sept.

Section C3 How you can change your care navigator

You may request a change in your Care Navigator if they are not right for you. Please call Enrollee Services at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, Oct–Mar; 8:00 a.m.–5:30 p.m., Monday–Friday, Apr–Sept if you need more information or help in choosing a new Care Navigator.

Section D Care from providers

Section D1 Care from a primary care provider (PCP)

Now that you are an enrollee of UHC Dual Choice DC-S001 (PPO D-SNP), your PCP (Primary Care Provider) will help you and your family to get the health care you need.

Definition of a PCP and what a PCP does do for you

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

A Primary Care Provider (PCP) is a licensed network doctor who is selected by you to provide or coordinate your covered services.

What types of providers may act as a PCP?

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

What is the role of my PCP?

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

It is important to call your PCP first when you need care. If you had a PCP before you signed up with UHC Dual Choice DC-S001 (PPO D-SNP), please call Enrollee Services at **1-866-242-7726**. We can help you stay with that PCP if you want to.

Your choice of PCP

Picking your PCP

1. Pick a PCP at the time you enroll in the Community Plan program with UHC Dual Choice DC-S001 (PPO D-SNP). This person will be your PCP while you are enrolled in UHC Dual Choice DC-S001 (PPO D-SNP).
   - If your current PCP is a Provider in UHC Dual Choice DC-S001 (PPO D-SNP)'s network, you may stay with that doctor
   - If you don't have a PCP, you can choose from a list of doctors in our **Provider Directory** or at **connect.werally.com/state-plan-selection/uhc.medicaid/state**
   - Call Enrollee Services at **1-866-242-7726**, TTY **711** if you need help in picking a doctor

- If you do not pick a PCP within the first 10 days of being in our plan, we will choose a doctor for you. If you do not like the PCP we pick for you, you may change your PCP. Call Enrollee Services at **1-866-242-7726**, TTY **711** to change your PCP.
- UHC Dual Choice DC-S001 (PPO D-SNP) will send you a UCard. Your PCP's name and phone number will be included on the letter mailed out to you.

2. Your PCP may be one of the following:
   - Family and General Practice Doctor — Usually can see the whole family
   - Internal Medicine Doctor — Usually sees only adults
   - Obstetrician/Gynecologist (OB/GYN) — Specializes in women's health and maternity care
   - If you have special health care needs, you may choose a specialist as your PCP
3. When you pick your PCP, please:
   - Try to pick a doctor who can send you to the hospital you want. Not all doctors can send patients to all hospitals. Our provider directory lists which hospitals a PCP can send you to. You can also call Enrollee Services for help.
   - Sometimes the PCP you choose won't be able to take new patients. We will let you know if you need to pick a different doctor.

Option to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

If you want to change your PCP, call Enrollee Services or go online. If you need help picking a new PCP, Enrollee Services can help you. If the PCP is accepting additional plan enrollees, the change will become effective on the first day of the following month. You will receive a new UHC Dual Choice DC-S001 (PPO D-SNP) UCard that shows your new PCP name and phone number.

Section D2 Care from specialists and other network providers

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

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

Even though your PCP is trained to handle most common health care needs, there may be a time when you feel that you need to see a network specialist. **You do not need a referral from your**

PCP to see a network specialist or behavioral/mental health provider. Although you do not need a referral from your PCP to see a network specialist, your PCP can recommend an appropriate network specialist for your medical condition, answer questions you have regarding a network specialist's treatment plan and provide follow-up health care as needed. For coordination of care, we recommend you notify your PCP when you see a network specialist.

Please refer to the **Provider Directory** for a listing of Plan specialists available through your network, or you may consult the **Provider Directory** online at **myuhc.com/CommunityPlan**.

How to access your behavioral/mental health benefit

To directly access your behavioral/mental health benefits, please call the behavioral health number at **1-866-242-7726** TTY **711**, 24 hours a day, 7 days a week. When you call, 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. You may also ask your PCP to call the number on the back of your enrollee UCard and arrange a referral on your behalf. You may also call to receive information about in-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.

Services for alcohol or other drug problems

Problems with alcohol or other drugs are dangerous to your health and can be dangerous to the health of people around you. It is important to go to the doctor if you need help with these problems. UHC Dual Choice DC-S001 (PPO D-SNP) will help you arrange for detoxification services and provide care coordination to help you get other services. To get services for these problems, you can:

- Call Enrollee Services at **1-866-242-7726**, TTY **711**
- Call the Department of Behavioral Health (DBH) Assessment and Referral Center (ARC) directly at **1-202-727-8473**

All mental health, alcohol and drug abuse services are confidential.

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

- a chronic (ongoing) condition;
- a life-threatening mental or physical illness;
- a degenerative disease or disability;

- any other condition or disease that is serious or complex enough to require treatment by a specialist.

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

Section D3 When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- 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 help you select a new qualified in-network provider to continue managing your health care needs.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we work with you to ensure, that the medically necessary treatment or therapies you are getting continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Covered services that may need approval in advance are marked in the Medical Benefits Chart.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. Please call Enrollee Services at **1-866-242-7726**, TTY **711**.

Section D4 Out-of-network providers

As an enrollee of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher.

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

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

Section E Long-term services and supports (LTSS)

You may be eligible for long-term care services and supports (LTSS). This includes care in a nursing facility or care in your own home. These services require prior authorization from UHC Dual Choice DC-S001 (PPO D-SNP) and may require you to meet certain requirements.

Your LTSS Care Manager can help you with:

- Getting covered services, including long-term care
- Arranging and providing care for enrollees in their homes through clinical exams, complete and emergent care management, and transitional care coordination following an acute inpatient stay
- Providing an integrated approach to managing all benefits for enrollees, including Long Term Services and Supports
- Developing and authorizing enrollee service plans and coordinating Home and Community Based Services (HCBS)
- Setting up medical appointments and tests
- Setting up transportation
- Finding ways to make sure you get the right service
- Finding resources to help with special health care needs and/or your caregivers manage day-to-day stress
- Connecting with community and social services

- Tracking clinical outcomes
- Meeting with care providers to review patient gaps in care
- Transitioning to other care when your benefits end, or you choose to move to another type of health care coverage

For more information about the clinical care program for individuals needing long-term services and supports, please contact our clinical care program at **1-855-409-7073**. Our staff can give you more information.

Section F Behavioral health (mental health and substance use disorder) services

Mental health care helps when you feel depressed or anxious. To directly access your behavioral/mental health benefits, please call the behavioral health number on the back of your Enrollee UCard 24 hours a day, 7 days a week. When you call, you will speak with a representative who will check your eligibility and gather basic information about you and your situation. Depending on experiencing and assess which provider and treatment would be appropriate for your situation. You may also ask your PCP to call the number on the back of your Enrollee UCard and arrange a referral on your behalf. You may also call to receive information about in-network practitioners, sub-specialty 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.

If you need help, or someone from your family needs help, call

- The DC Department of Behavioral Health Hot Line at **1-888-793-4357**, 24 hours a day, 7 days a week
- **911** for help or go to the nearest emergency room or hospital

How to access your behavioral/mental health benefit

To directly access your behavioral/mental health benefits, please call the behavioral health number at **1-866-242-7726**, TTY **711**, 24 hours a day, 7 days a week. When you call, 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.

You may also ask your PCP to call the number on the back of your enrollee UCard and arrange a referral on your behalf. You may also call to receive information about in-network practitioners, sub-specialty 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.

Services for alcohol or other drug problems

Problems with alcohol or other drugs are dangerous to your health and can be dangerous to the health of people around you. It is important to go to the doctor if you need help with these problems. UHC Dual Choice DC-S001 (PPO D-SNP) will help you arrange for detoxification services and provide care coordination to help you get other services. To get services for these problems, you can:

- Call Enrollee Services at **1-866-242-7726**, TTY **711**
- Call the Department of Behavioral Health (DBH) Assessment and Referral Center (ARC) directly at **1-202-727-8473**

All mental health, alcohol and drug abuse services are confidential.

Section G Covered services in a medical emergency, when urgently needed, or during a disaster

Section G1 Care in a medical emergency

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

- Serious risk to your health or to that of your unborn child; **or**
- Serious harm to bodily functions; **or**
- Serious dysfunction of any bodily organ or part.

If you have a medical emergency:

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

As soon as possible, tell our plan about your emergency. We follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours by calling Enrollee Services at **1-866-242-7726**, TTY **711**. However, you won't pay for emergency services if you delay telling us. Call Enrollee Services at **1-866-242-7726**, TTY **711**.

Covered services in a medical emergency

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Medical Benefits Chart in **Chapter 4** of your **Enrollee Handbook**.

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

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

Getting emergency care if it wasn't an emergency

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

After the doctor says it wasn't an emergency, we cover your additional care **only** if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

Section G2 Urgently needed care

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

Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

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

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

Check your **Provider Directory** for a list of network Urgent Care Centers.

Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider.

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

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 G3 Care during a disaster

If the governor of your district, 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 our plan.

Visit our website for information on how to get care you need during a declared disaster: **myuhc.com/CommunityPlan.**

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at the in-network cost-sharing rate. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of your **Enrollee Handbook** for more information.

Section H What to do if you are billed directly for services our plan covers

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay the bill.

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

If you paid for your covered services or if you got a bill for the full cost of covered medical services, refer to **Chapter 7** of your **Enrollee Handbook** to find out what to do.

Section H1 What to do if our plan does not cover services

Our plan covers all services:

- That are determined medically necessary, **and**
- That are listed in our plan's Medical Benefits Chart (refer to **Chapter 4** of your **Enrollee Handbook**), **and**
- That you get by following plan rules.

DC Medicaid covers some services that are not covered by this program (for example, some community-based behavioral health services).

If you get services that neither our plan nor DC Medicaid covers, **you pay the full cost yourself.**

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

Chapter 9 of your **Enrollee Handbook** explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Enrollee Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Enrollee Services to find out what the benefit limits are and how much of your benefits you've used.

Section I Coverage of health care services in a "clinical research study"

Section I1 Definition of a "clinical research study"

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

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

While you're in the study, you may stay enrolled in our plan. That way, our plan continues to cover you for services and care not related to the study.

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

We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care coordinator to contact Enrollee Services to let us know you will take part in a clinical trial.

Section I2 Payment for services when you are in a clinical research study

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

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

If you're part of a study that Medicare has **not** approved, you pay any costs for being in the study.

Section I3 More about clinical research studies

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

Section J How your health care services are covered in a religious non-medical health care institution

Section J1 Definition of a religious non-medical health care institution

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

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

Section J2 Care from a religious non-medical health care institution

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

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

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free. For more information, visit **myuhc.com/CommunityPlan**.

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

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

Medicare Inpatient Hospital coverage limits apply. The coverage limits are described under **Inpatient Hospital Care** in the Medical Benefits Chart in **Chapter 4**.

Section K Durable medical equipment (DME)

Section K1 DME as an enrollee of our plan

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

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. As an enrollee of our plan, you usually will **not** own DME, no matter how long you rent it.

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

Section K2 DME ownership if you switch to Original Medicare

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

Note: You can find definitions of Original Medicare and MA Plans in **Chapter 12**. You can also find more information about them in the **Medicare & You 2024** handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (**medicare.gov/medicare-and-you**) or by

calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

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

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

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

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

Section K3 Oxygen equipment benefits as an enrollee of our plan

If you qualify for oxygen equipment covered by Medicare and you're an enrollee of our plan, we cover:

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

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

Section K4 Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

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

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- Oxygen equipment, supplies, and services for another 24 months
- Oxygen equipment and supplies for up to 5 years if medically necessary

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

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

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

Chapter 4

Medical Benefits Chart
(what we cover and what you pay)

Chapter 4

Medical Benefits Chart (what we cover and what you pay)

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services and how much you pay for each service. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your **Enrollee Handbook**.

Section A Your covered services

This chapter tells you about services our plan covers as an enrollee of UHC Dual Choice DC-S001 (PPO D-SNP). You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your **Enrollee Handbook**.

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

If you need help understanding what services are covered, call your care coordinator or Enrollee Services at **1-866-242-7726**, TTY **711**.

Grace Period

Enrollees who have full Medicaid Benefits and lose your Medicaid eligibility, we will provide you a 6-month grace period while you reapply for assistance. You will remain enrolled in our Plan during this time.

During the grace period, if you do go to your provider, you will have out-of-pocket costs that your Medicare plan will not cover. You will be responsible for those costs until you regain your Medicaid eligibility. Your out-of-pocket costs may include Medicare plan deductibles, copayments and coinsurance up to the Original Medicare amounts, which can be found at medicare.gov.

In addition, you will need to pay the plan premium previously covered by DC Department of Healthcare Finance. You always remain responsible for the Part B premium unless this amount is paid on your behalf. Please call Enrollee Service at **1-866-242-7726** for additional information related to out-of-pocket costs during the grace period.

Please keep copies of your bills and receipts for any care received during the grace period. Also keep a copy of any letter or other documentation regarding your loss of DC Medicaid eligibility so we can verify eligibility for the grace period.

If you do not regain Medicaid eligibility during the grace period, you will be disenrolled from our plan and will return to Original Medicare if you are eligible for Original Medicare. If you are not eligible for Medicare benefits you must check with your State Medical Assistance agency to see if there are any other public programs available to you. If you receive notice that your Medicaid overage has expired, please contact the Medicaid office as soon as possible to reapply for assistance. Your DC Medicaid Agency phone number is **1-202-442-9533**. Please contact UnitedHealthcare Enrollee Services at **1-866-242-7726**, TTY **711** if you have questions.

Section A1 During public health emergencies

During a declared public health emergency (e.g., the COVID-19 pandemic), if you get medically necessary services from an out-of-network provider at any time during the public health emergency, please call us to help you obtain reimbursement for any out of pocket expense you might have incurred. Please call the Enrollee Services at **1-866-242-7726**, TTY **711**, from 8 a.m.–8 p.m., 7 days a week, Oct–Mar; 8 a.m.–5:30 p.m., Monday–Friday, Apr–Sept for more information.

Section B Rules against providers charging you for services

We don't allow our providers to bill you for in-network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of your **Enrollee Handbook** or call Enrollee Services.

Section C About our plan's Medical Benefits Chart

The Medical Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Medical Benefits Chart when the following rules are met.

- We provide covered Medicare and DC Medicaid covered services according to the rules set by Medicare and DC Medicaid.
- The services (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs) must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your **Enrollee Handbook** has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care.

- If you are receiving treatment authorized and covered by DC Medicaid at the time of enrollment in this plan, you may continue this treatment, regardless of whether the provider is in UHC Dual Choice DC-S001 (PPO D-SNP)'s provider network until the course of treatment is concluded, or for 30 days, whichever is longer. If your provider is not currently in UHC Dual Choice DC-S001 (PPO D-SNP)'s network, then you may be asked to select a new provider that is within UHC Dual Choice DC-S001 (PPO D-SNP)'s provider network.
- If your health care provider leaves UHC Dual Choice DC-S001 (PPO D-SNP)'s network, we will notify you within 15 calendar days, so that you have time to select another provider. If UHC Dual Choice DC-S001 (PPO D-SNP) terminates your provider, we will notify you within 30 calendar days prior to the effective date of termination.
- We cover some services listed in the Medical Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Medical Benefits Chart that need PA with a footnote.

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

- Because UHC Dual Choice DC-S001 (PPO D-SNP) participates in D-SNP Healthy Food, you will be eligible for the following WHP services, including advance care planning (ACP) services:
  - What are ACP services?
    - Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in his 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 are if you become unable to make decisions for yourself.
      - You may get advance care planning assistance by contacting Enrollee Services at **1-866-242-7726** TTY **711**.

Important Benefit Information for Enrollees Who Qualify for Extra Help

- If you receive Extra Help to pay your Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.
- Please go to the Medical Benefits Chart in **Chapter 4** for further detail.

Most **or** all preventive services are free. You will find this apple next to preventive services in the Medical Benefits Chart.

Benefits, features and/or devices vary by plan/area. Limitations, exclusions and/or network restrictions may apply.

Section D Our plan's Medical Benefits Chart

Services that our plan pays for	What you must pay
Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In-Network** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. **Out-of-Network** $0 copayment or 30% coinsurance for members eligible for this preventive screening. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Acupuncture We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. **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 district requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, **This benefit is continued on the next page**	**In-Network** You will pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/ practitioner services, including doctor's office visits") depending on if you receive services from a primary care physician or specialist.†† **Out-of-Network** You will pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/ practitioner services, including doctor's office visits") depending on if you receive services from a primary care physician or specialist.

Services that our plan pays for	What you must pay
Acupuncture (continued) • 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 required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Out-of-Network** $0 copayment or 30% coinsurance for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0 copayment for each one-way Medicare-covered ground trip (in-network). $0 copayment or 20% of the total cost for each one-way Medicare-covered ground trip (out-of-network). $0 copayment for each one-way Medicare-covered air trip (in-network). $0 copayment or 20% of the total cost for each one-way Medicare-covered air trip (out-of-network). You pay these amounts until you reach the out-of-pocket maximum. All Medicare-covered trips (in or out-of-network) will apply to the in-network out-of-pocket maximum. *Your provider may need to obtain prior authorization for non-emergency transportation*.
Annual routine physical exam Includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. Annual Routine Physical Exam visits do not need to be scheduled 12 months apart but are limited to one in or out-of-network visit each calendar year.	**In-Network** $0 copayment for a routine physical exam each year. **Out-of-Network** 30% coinsurance for a routine physical exam each year.*

Services that our plan pays for	What you must pay
Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. This is covered once every 12 months. Doesn't include lab tests, radiological diagnostic tests, or non-radiological diagnostic tests. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Welcome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	**In-Network** There is no coinsurance, copayment, or deductible for the annual wellness visit. **Out-of-Network** $0 copayment or 30% coinsurance for the annual wellness visit. You pay these amounts until you reach the out-of-pocket maximum.
Auxiliary aid services for the hearing and visually impaired If you have trouble hearing, call Enrollee Services at **1-866-242-7726**, TTY **711**. If you have trouble seeing, call Enrollee Services at **1-866-242-7726**, TTY **711**. We can give you information on an audio tape, in braille or in large print.	$0

Services that our plan pays for	What you must pay
Behavioral Health Covered • Community Support • Crisis Stabilization • Observation • Partial Hospitalization • Psychiatric Day Treatment • Residential Substance Abuse Treatment • Structured Outpatient Addiction Programs • Emergency Screening Service • Medication Management Services • Short-Term Crisis Counseling • Short-Term Crisis Stabilization Services • Specializing Services • Outpatient Mental Health Services • Outpatient Substance Abuse Services • Electro-Convulsive Therapy • Psychological Neuropsychological Testing We pay for the following behavioral health services: Inpatient: • Hospitalization • Psychiatric facility services • Detoxification **This benefit is continued on the next page**	$0††

Services that our plan pays for	What you must pay
Behavioral Health (continued) Outpatient: • Emergency Department Services • Case Management Services • Pregnancy related services • Outpatient Alcohol and Drug Abuse Treatment (Clinic and OLP services.) Physician Services • Diagnostic and Assessment Services • Individual/Group/Family counseling • Federally quaified health center (FQHC) services • Medication/Somatic Treatment **Services Payable by Department of Behavioral Health (DBH):** • Community-Based Interventions • Multi-Systemic Therapy (MST) • Assertive Community Treatment (ACT) • Transitional Assertive Community Treatment (TACT) • Community Support • Recovery Support Services • Vocational Supported Employment • Clubhouse Services • Trauma Recovery Empowerment Model (TREM) • Trauma Systems Therapy (TST) • Functional Family Therapy (FFT) • Outpatient Rehabilitation services • Other Services Provided by DBH	

Services that our plan pays for	What you must pay
Bone mass measurement We pay for certain procedures for enrollees who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement. **Out-of-Network** $0 copayment or 30% coinsurance for the Medicare-covered bone mass measurement. You pay these amounts until you reach the out-of-pocket maximum.
Breast cancer screening (mammograms) We pay for the following services: • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	**In-Network** There is no coinsurance, copayment, or deductible for covered screening mammograms. **Out-of-Network** $0 copayment or 30% coinsurance for screening mammograms. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Enrollees must meet certain conditions and have a doctor's order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	**In-Network** There is no coinsurance, copayment, or deductible for each Medicare-covered cardiac rehabilitative visit.†† **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered cardiac rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum.
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • Discuss aspirin use, • Check your blood pressure, **and/or** • Give you tips to make sure you are eating well.	**In-Network** There is no coinsurance, copayment, or deductible for the cardiovascular disease preventive benefit. **Out-of-Network** $0 copayment or 30% coinsurance for the cardiovascular disease preventive benefit. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Cardiovascular (heart) disease testing We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	**In-Network** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years. **Out-of-Network** $0 copayment or 30% coinsurance for cardiovascular disease testing that is covered once every five years. You pay these amounts until you reach the out-of-pocket maximum.
Cervical and vaginal cancer screening We pay for the following services: • For all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • For women who have had an abnormal Pap test within the last three years and are of childbearing age: 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	**In-Network** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. **Out-of-Network** $0 copayment or 30% coinsurance for Medicare-covered preventive Pap and pelvic exams. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Chiropractic services We pay for the following services: • Adjustments of the spine to correct alignment • Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation.	**In-Network** $0 copayment for each Medicare covered visit.†† **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Colorectal cancer screening We pay for the following services: • Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.	**In-Network** There is no coinsurance, copayment, or deductible for Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes an outpatient diagnostic colonoscopy. There is no coinsurance, copayment, or deductible for each Medicare-covered barium enema. **Out-of-Network** $0 copayment or 30% coinsurance for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes an outpatient diagnostic colonoscopy. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% coinsurance for each Medicare-covered barium enema. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Colorectal cancer screening Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	

Services that our plan pays for	What you must pay
Dental services We pay for the following services: • General dental examinations/preventive services • Surgical services and extractions • Emergency care • Fillings • Reline or rebase of a removable denture, limited to two (2) in five (5) years unless there is a prior authorization • Complete radiographic survey, full series of X-rays or panoramic X-ray of the mouth, limited to once every three years; additional requires prior authorization • Full mouth debridement • Oral prophylaxis, limited to once every six months • Bitewing series • Palliative treatment • Sealant application • Removable partial and full dentures • Root canal treatment • Periodontal scaling and root planning • Removal of impacted teeth • Initial placement or replacement of a removable prosthesis, one per arch every five (5) years per beneficiary, unless the prosthesis was missing, stolen, damaged or cannot be modified • A removable partial prosthesis • Dental implants, require authorization **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Dental services (continued) We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.	
Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	**In-Network** There is no coinsurance, copayment, or deductible for an annual depression screening visit. **Out-of-Network** $0 copayment or 30% coinsurance for an annual depression screening visit. You pay these amounts until you reach the out-of-pocket maximum.
Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. **Out-of-Network** $0 copayment or 30% coinsurance for the Medicare-covered diabetes screening tests. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: – A blood glucose monitor – Blood glucose test strips – Lancet devices and lancets – Glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, we pay for the following: – One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** – One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Enrollee Services. **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered diabetes monitoring supply.†† We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, OneTouch® Verio, OneTouch®Ultra 2, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan. You pay a $0 for the diabetes self-management training preventive benefit. You pay a $0 for Medicare-covered Continuous Glucose Monitors or supplies in accordance with Medicare guidelines. There are no brand limitations for Continuous Glucose Monitors.†† You pay a $0 for each Medicare-covered diabetes monitoring supply.†† You pay a $0 for each pair of Medicare-covered therapeutic shoes.††

Services that our plan pays for	What you must pay
Diabetic self-management training, services, and supplies (continued) We will generally not cover alternate brands unless your doctor or other provider tells us that use of an alternate brand is medically necessary in your specific situation. If you are new to our plan and are using a brand of blood glucose monitors and test strips that are not on our list, you may contact us within the first 90 days of enrollment into the plan to request a temporary supply of the alternate brand while you consult with your doctor or other provider. During this time, you should talk with your doctor to decide whether any of the preferred brands are medically appropriate for you. If you or your doctor believes it is medically necessary for you to maintain use of an alternate brand, you may request a coverage exception to have us maintain coverage of a non-preferred product through the end of the benefit year. Non-preferred products will not be covered following the initial 90 days of the benefit year without an approved coverage exception. If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see **Chapter 9**, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).	**Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered diabetes monitoring supply. You pay these amounts until you reach the out-of- pocket maximum. $0 copayment or 30% coinsurance for each Medicare-covered continuous glucose monitor and supplies in accordance with Medicare guidelines. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% coinsurance for each pair of Medicare-covered therapeutic shoes. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% coinsurance for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of your **Enrollee Handbook** for a definition of "Durable medical equipment (DME)." We cover the following items: • Wheelchairs • Crutches • Powered mattress systems • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps and pole • Speech generating devices • Oxygen equipment and supplies • Nebulizers • Walkers • Standard curved handle or quad cane and replacement supplies • Cervical traction (over the door) • Bone stimulator • Dialysis care equipment • Incontinence supplies (diapers/wipes) • Nutritional supplements • Enteral formula • Bath chairs • Tub and shower grab bars Other items may be covered. **This benefit is continued on the next page**	**In-Network** $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.†† **Out-of-Network** $0 copayment or 30% coinsurance for Medicare-covered benefits. Your cost sharing for Medicare oxygen equipment coverage is $0 copayment or 30% coinsurance every time you get covered equipment or supplies. Your cost sharing will not change after being enrolled for 36 months. If prior to enrolling in our plan you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in our plan is $0 copayment or 30% coinsurance.

Services that our plan pays for	What you must pay
Durable medical equipment (DME) and related supplies (continued) We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.	You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Emergency care Emergency care means services that are: • Given by a provider trained to give emergency services, **and** • Needed to treat a medical emergency. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • Serious risk to your health or to that of your unborn child; **or** • Serious harm to bodily functions; **or** • Serious dysfunction of any bodily organ or part. Worldwide coverage for emergency department services outside of the United States. • This includes emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. • Transportation back to the United States from another country is not covered. • Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures are not covered. • Services provided by a dentist are not covered.	$0 copayment for each emergency room visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you are admitted to a hospital, you will pay cost-sharing as described in the "Inpatient hospital care" section in this benefit chart. $0 copayment for worldwide coverage for emergency services outside of the United States. Please see **Chapter 8, Section A** 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 either receive authorization to stay at the out-of-network hospital or move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.

Services that our plan pays for	What you must pay
Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests (including pregnancy testing) • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, ring, or emergency contraception) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • general counseling • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) (including immunizations for Human Papilloma Virus) • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • genetic counseling **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Family planning services (continued) We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	
Fitness program Renew Active® by UnitedHealthcare® Renew Active by UnitedHealthcare is the gold standard in Medicare fitness programs for body and mind. It's available to you at no additional cost and includes: • A free gym membership, access to our nationwide network of gyms and fitness locations, a personalized fitness plan plus thousands of on-demand workout videos and live streaming fitness classes. • An online program from AARP® Staying Sharp® offering content about brain health with exclusive content for Renew Active members. • Social activities at local health and wellness classes, clubs and events. • An online Fitbit® Community for Renew Active. No Fitbit device is needed. You can get more information by viewing the **Vendor Information Sheet** at **myuhc.com/communityplan** or by calling Enrollee Services to have a paper copy sent to you.	Provided by: Renew Active® $0 copayment A home-delivered fitness kit is available if you live 15 miles or more from a Renew Active network gym or fitness location.

Services that our plan pays for	What you must pay
Routine hearing exam This benefit covers one exam every year. This benefit is combined in and out-of-network. **Hearing services** We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	**In-Network** $0 copayment for each Medicare-covered exam.†† Provided by: Plan network providers in your service area. $0 copayment **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum.
HIV screening We pay for one HIV screening exam every 12 months for people who: • Ask for an HIV screening test, **or** • Are at increased risk for HIV infection. For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.	**In-Network** There is no coinsurance, copayment, or deductible for enrollees eligible for Medicare-covered preventive HIV screening. **Out-of-Network** $0 copayment or 30% coinsurance for enrollees eligible for Medicare-covered preventive HIV screening. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Home and Community-Based Long-term Services and Supports In-home health care services, including: • Nursing and home health aide care • Personal care aide services provided by a home health agency • Physical therapy, occupational therapy, speech pathology and audiology services • Adult day health program services EPD Waiver services, including: • Assisted living services in an assisted living facility • Participant-directed in-home services and supports • Personal care aide services provided by a home health agency • Chore aide or homemaker supports • Adult Day Health Program Services Care coordination for enrollees enrolled in: • The Medicaid Waiver for People with Intellectual or Developmental Disabilities • The Medicaid Individual and Family Support Waiver *You must get prior authorization for long-term services and supports.*	$0

Services that our plan pays for	What you must pay
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**In-Network** $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). **Out-of-Network** $0 copayment or 30% coinsurance 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). You pay these amounts until you reach the out-of-pocket maximum.

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

Services that our plan pays for	What you must pay
Home infusion therapy (continued)	See “Durable medical equipment” earlier in this chart for any applicable cost-sharing for equipment and supplies related to home infusion therapy. See "Medicare Part B prescription drugs" later in this chart for any applicable cost-sharing for drugs related to home infusion therapy.
Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan’s service area. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs to treat symptoms and pain • Short-term respite care • Home care **Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Refer to **Section F** of this chapter for more information. **This benefit is continued on the next page**	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not UHC Dual Choice DC-S001 (PPO D-SNP).

Services that our plan pays for	What you must pay
Hospice care (continued) **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay our plan's cost-sharing amount for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your **Enrollee Handbook**. **Note:** If you need non-hospice care, call your care coordinator and/or enrollee services to arrange the services. Non-hospice care is care that is **not** related to your terminal prognosis. Getting your non-hospice care through our network providers will lower your share of the costs for the services. Our plan covers hospice consultation services (one time only) for a terminally ill enrollee who has not chosen the hospice benefit.	

Services that our plan pays for	What you must pay
Immunizations We pay for the following services: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules.	There is no coinsurance, copayment, or deductible for the pneumonia, flu, Hepatitis B, or COVID-19 vaccines. There is no coinsurance, copayment, or deductible for all other Medicare-covered immunizations. This benefit is combined in and out-of-network.

Services that our plan pays for	What you must pay
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. We pay for the following services and other medically necessary services not listed here: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance abuse services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered hospital stay for unlimited days 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 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 our plan pays for	What you must pay
Inpatient hospital care (continued) The plan's hospital network for organ transplant services is different than the network shown in the `Hospitals' section of your **Provider Directory**. Some hospitals in the plan's network for other medical services are not in the plan's network for transplant services. For information on network facilities for transplant services, please call UHC Dual Choice DC-S001 (PPO D-SNP) Enrollee Services at **1-866-242-7726**, 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 the service area. If our in-network transplant providers are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If UHC Dual Choice DC-S001 (PPO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. While you are receiving care at the distant location, we will also reimburse transportation costs to and from the hospital or doctor's office for evaluations, transplant services and follow-up care. (Transportation in the distant location includes, but is not limited to: vehicle mileage, economy/ coach airfare, taxi fares, or rideshare services.) Costs for lodging or places to stay such as hotels, motels, or short-term housing as a result of travel for a covered organ transplant may also be covered. You can be reimbursed for eligible costs up to $125 per day total. Transportation services are not subject to the daily limit amount. **This benefit is continued on the next page**	**Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered hospital stay for unlimited days each time you are admitted. You pay these amounts until you reach the out-of-pocket maximum. 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 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 our plan pays for	What you must pay
Inpatient hospital care (continued) • Blood, including storage and administration • 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 Hosptial 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.	

Services that our plan pays for	What you must pay
Inpatient services in a psychiatric hospital We pay for 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 inpatient mental health services provided in a psychiatric unit of a general hospital. • Inpatient substance abuse services **This benefit is continued on the next page**	**In-Network** $0 copayment up to 90 days per benefit period, plus an additional 60 lifetime reserve days.†† 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. **Out-of-Network** $0 copayment or 30% coinsurance for Medicare-covered hospital care each time you are admitted, up to 90 days per benefit period. Plus an additional 60 lifetime reserve days. You pay these amounts until you reach the out-of-pocket maximum. Medicare hospital benefit periods are used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in the chapter titled Definitions of important words.)

Services that our plan pays for	What you must pay
Inpatient services in a psychiatric hospital (continued)	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.

Services that our plan pays for	What you must pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We do not pay for your inpatient stay if you have used all of your inpatient benefit or if the stay is not reasonable and medically necessary. However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Enrollee Services. We pay for the following services, and maybe other services not listed here: • Doctor services • Diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • Surgical dressings • Splints, casts, and other devices used for fractures and dislocations • Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: – An internal body organ (including contiguous tissue), **or** – The function of an inoperative or malfunctioning internal body organ. • Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition • Physical therapy, speech therapy, and occupational therapy	When your stay is no longer covered, these services will be covered as described in the following sections: Please refer below to Physician/ practitioner services, including doctor's office visits. Please refer below to Outpatient diagnostic tests and therapeutic services and supplies. Please refer below to Prosthetic devices and related supplies. Please refer below to Outpatient rehabilitation services.

Services that our plan pays for	What you must pay
Interpretation and Translation Services UHC Dual Choice DC-S001 (PPO D-SNP) provides oral Interpretation Services if you need them for FREE, including at the hospital. Please call Enrollee Services at **1-866-242-7726**, TTY **711** to get Interpretation Services. Please call us before your doctor's appointment if you need Interpretation Services.	$0

Services that our plan pays for	What you must pay
Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of your **Enrollee Handbook**, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.	**In-Network** $0 copayment for Medicare-covered benefits. $0 copayment for Medicare-covered benefits.†† These services will be covered as described in the following sections: Please refer to Inpatient hospital care. Please refer to Durable medical equipment and related supplies. Please refer to Home health agency care. **Out-of-Network** $0 copayment or 20% coinsurance for Medicare-covered benefits. $0 copayment or 30% coinsurance for Medicare-covered benefits. These services will be covered as described in the following sections: Please refer to Inpatient hospital care. Please refer to Durable medical equipment and related supplies. Please refer to Home health agency care.

Services that our plan pays for	What you must pay
Lung cancer screening Our plan pays for lung cancer screening every 12 months if you: • Are aged 50–77, **and** • Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT. **Out-of-Network** $0 copayment or 30% coinsurance for the Medicare-covered counseling and shared decision making visit or for the LDCT. You pay these amounts until you reach the out-of-pocket maximum.
Meal benefit This benefit can be used immediately following an inpatient hospital or skilled nursing facility (SNF) stay if recommended by a provider. Benefit guidelines: • Receive up to 28 home-delivered meals for up to 14 days • First meal delivery may take up to 72 hours after ordered • Some restrictions and limitations may apply	Provided by: Roots Food Group® $0 copayment Prior authorization is required. Home-delivered meals are available nationwide through Roots Food Group®.

Services that our plan pays for	What you must pay
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare). We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	**In-Network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. **Out-of-Network** $0 copayment or 30% coinsurance for members eligible for Medicare-covered medical nutrition therapy services. You pay these amounts until you reach the out-of-pocket maximum.
Medicare Diabetes Prevention Program (MDPP) Our plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • Long-term dietary change, **and** • Increased physical activity, **and** • Ways to maintain weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Services that our plan pays for	What you must pay
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery 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 our plan authorized • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit. **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered chemotherapy drug and the administration of that drug.†† $0 copayment for each Medicare-covered Part B drug.†† 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 our plan pays for	What you must pay
Medicare Part B prescription drugs (continued) **Chapter 5** of your **Enrollee Handboo**k explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.	**Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered chemotherapy drug and the administration of that drug. $0 copayment or 30% coinsurance for each Medicare-covered Part B drug.†† 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. You pay these amounts until you reach the out-of-pocket maximum.
Nurse Hotline Nurse Hotline services available, 24 hours a day, 7 days a week. Speak to a registered nurse (RN) about your medical concerns and questions. You can view the **Vendor Information Sheet** at **myuhc.com/CommunityPlan**, or call Enrollee Services to have a paper copy sent to you.	Provided by: NurseLine

Services that our plan pays for	What you must pay
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	**In-Network** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. **Out-of-Network** $0 copayment or 30% coinsurance for preventive obesity screening and therapy. You pay these amounts until you reach the out-of-pocket maximum.
Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD): • Intake activities • Periodic assessments • Medications approved by the FDA and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing)	$0 copayment for Medicare-covered opioid treatment program services.††
Orthotics Including braces (non-dental) and other mechanical or molded devices to support or correct any defect of form or function.	$0

Services that our plan pays for	What you must pay
Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • Radiation (radium and isotope) therapy, including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used for fractures and dislocations **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. • Lab tests • Blood, including storage and administration, coverage begins with the first pint of blood that you need. • Other outpatient diagnostic tests – Non-radiological diagnostic services – Radiological diagnostic services, not including X-rays performed in a physician's office or at a freestanding facility (such as a radiology center or medical clinic). • The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered standard X-ray service.†† $0 copayment for each Medicare-covered radiation therapy service.†† $0 copayment for each Medicare-covered medical supply.†† $0 copayment for Medicare-covered lab services.†† $0 copayment for Medicare-covered blood 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. $0 copayment for Medicare-covered radiological diagnostic services, not including Xrays, performed in a physician's office or at a free-standing facility (such as a radiology center or medical clinic).††

Services that our plan pays for	What you must pay
Outpatient diagnostic tests and therapeutic services and supplies (continued) 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). **This benefit is continued on the next page**	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). **Out-of-Network** $0 copayment or 30% for each Medicare-covered standard X-ray service. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% for each Medicare-covered radiation therapy service. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% for each Medicare-covered medical supply. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment for Medicare-covered lab services. $0 copayment or 30% for Medicare-covered blood services.

Services that our plan pays for	What you must pay
Outpatient diagnostic tests and therapeutic services and supplies (continued)	You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% for Medicare-covered non-radiological diagnostic services. Examples include, but are not limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment for Medicare-covered radiological diagnostic services, not including Xrays, performed in a physician's office or at a free-standing facility (such as a radiology center or medical clinic). You pay these amounts until you reach the out-of-pocket maximum. The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).

Services that our plan pays for	What you must pay
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. 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/2021-10/11435Inpatient-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 our plan pays for	What you must pay
Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services – Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.” – Sometimes you can be in the hospital overnight and still be “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff. – You can get more information about being inpatient or outpatient in this fact sheet: **medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf**. • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Medical Benefits Chart • Some drugs that you can’t give yourself • Services performed at an outpatient clinic • Outpatient surgery or observation • Outpatient infusion therapy **This benefit is continued on the next page**	Please refer to Emergency Care. Please refer to Outpatient diagnostic tests and therapeutic services and supplies. Please refer to Outpatient mental health care. Please refer to Outpatient diagnostic tests and therapeutic services and supplies. Please refer to Outpatient diagnostic tests and therapeutic services and supplies. Please refer to the benefits preceded by the "Apple" icon. Please refer to Medicare Part B prescription drugs. Please refer to Physician/practitioner services, including doctor's office visits. Please refer to Outpatient surgery and other medical 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.

Services that our plan pays for	What you must pay
Outpatient hospital services (continued)	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
Outpatient mental health care We pay for mental health services provided by: • A state-licensed psychiatrist or doctor • A clinical psychologist • A clinical social worker • A clinical nurse specialist • A licensed professional counselor (LPC) • A licensed marriage and family therapist (LMFT) • A nurse practitioner (NP) • A physician assistant (PA) • Any other Medicare-qualified mental health care professional as allowed under applicable state laws In addition, Medicaid may cover the following services: • Behavioral Health Emergency Services • Observation • Community Support Services • Federally Qualified Health Center (FQHC) Services • Day Treatment • Residential programs • Crisis stabilization • Psychiatric day treatment	**In-Network** $0 copayment for each Medicare-covered **individual** therapy session.†† $0 copayment for each Medicare-covered **group** therapy session.†† **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered **individual** therapy session. $0 copayment or 30% coinsurance for each Medicare-covered **group** therapy session. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	**In-Network** $0 copayment for each Medicare-covered physical therapy and speech-language therapy visit.†† $0 copayment for each Medicare-covered occupational therapy visit.†† **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered physical therapy and speech-language therapy visit. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% coinsurance for each Medicare-covered occupational therapy visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Outpatient substance abuse services We pay for the following services, and maybe other services not listed here: • Alcohol misuse screening and counseling • Treatment of drug abuse • Group or individual counseling by a qualified clinician • Subacute detoxification in a residential addiction program • Alcohol and/or drug services in an intensive outpatient treatment center • Extended-release naltrexone (Vivitrol) treatment • Clinical and Other Licensed Practitioners (OLP) • Outpatient rehabilitation services are covered under the Department of Behavioral Health (DBH)	**In-Network** $0 copayment for each Medicare-covered **individual** therapy session.†† $0 copayment for each Medicare-covered **group** therapy session.†† **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered **individual** therapy session. $0 copayment or 30% coinsurance for each Medicare-covered **group** therapy session. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers We pay for outpatient surgery and services 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, such as diagnostic tests, therapeutic services, prosthetics, orthotics, supplies or Part B drugs, there will be no cost-sharing for those services or items. Please refer to the appropriate section in this chart for the additional service or item you received.	**In-Network** $0 copayment for Medicare-covered surgery or other services provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges.†† $0 copayment for Medicare-covered surgery or other services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgicalcharges.†† 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 each day of Medicare-covered observation services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges.††

Services that our plan pays for	What you must pay
Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers (continued)	**Out-of-Network** $0 copayment or 30% coinsurance for Medicare-covered surgery or other services provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% coinsurance for Medicare-covered surgery or other services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment for each day of Medicare-covered observation services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum.
Over-the-Counter (OTC) drugs based on our formulary • Select prescription and OTC drugs listed on the UHC Dual Choice DC-S001 (PPO D-SNP) Drug List not covered under the Medicare Part D benefit.	Covered by Medicaid

Services that our plan pays for	What you must pay
Over-the-Counter (OTC) + Healthy food card (covered for all DC Medicaid enrollees as an additional benefit under our plan) With this benefit, you'll get a credit loaded to your UnitedHealthcare UCard® each month to pay for covered healthy food, OTC items and utility bills. Unused credits expire at the end of each month. Covered items include: • Healthy foods like fruits, vegetables, meat, seafood, dairy products, water and more. • Brand name and generic OTC products, like vitamins, pain relievers, toothpaste, first aid products and more. • Eligible utility bills like electricity, home heat like natural gas, water and home internet. The service address must match an address we have on file for you. The credit cannot be used to buy tobacco or alcohol. **Home and bath safety devices** You can also use your OTC credit on covered home and bath safety devices like bathmats, grab bars and shower chairs. You can use your credit at thousands of participating stores or place an order online. Home shipping is free and there is a $35 minimum to place an order. You can also use your credit to pay eligible utility bills from network companies online or at your local Walmart MoneyCenter or Customer Service Desk. Visit the UCard Hub at **myuhc.com/communityplan** to find participating stores, check your balance, place an order online or pay utility bills.	Provided by Solutran Monthly credit is $119 Over-the-Counter (OTC) items that are not found on the formulary should be covered under the Medicaid OTC benefit.

Services that our plan pays for	What you must pay
Partial hospitalization 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.	**In-Network** $0 copayment each day for Medicare-covered benefits.†† **Out-of-Network** $0 copayment or 30% coinsurance each day for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.
Personal Emergency Response System (PERS) With a Personal Emergency Response System (PERS), help is a button press away. A PERS device can quickly connect you to the help you need, 24 hours a day in any situation. It's a lightweight, discreet button that can be worn on your wrist or as a pendant. It's also safe to wear in the shower or bath. Depending on the model you choose, it may even automatically detect falls. You must have a working landline or live in an area that has appropriate wireless coverage to get a PERS device. The cellular device works nationwide with the wireless network but does not require you to have a contract with the network. You can view the **Vendor Information Sheet** at **myuhc.com/CommunityPlan**, or call Enrollee Services to have a paper copy sent to you.	$0 Provided by: Lifeline A home-delivered device is available nationwide through Lifeline.

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits We pay for the following services: • Medically necessary health care or surgery services given in places such as: – Physician's office – Certified ambulatory surgical center – Hospital outpatient department – Consultation, diagnosis, and treatment by a specialist – Basic hearing and balance exams given by your specialist, if your doctor orders them to find out whether you need treatment • Additional Mental Health telehealth visits: – Covered services include individual mental health services – Virtual Mental Health Visits are mental health visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/video capabilities. Visit **virtualvisitsmentalhealth.uhc.com** to learn more and schedule a virtual appointment. – You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. – Virtual Medical Visits are medical visits delivered to you outside of medical facilities by network providers that have appropriate online technology and live audio/video capabilities to conduct the visit. – Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment. **This benefit is continued on the next page**	**In-Network** $0 copayment for services from a primary care physician or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a primary care physician's office (as allowed by Medicare). 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. $0 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).†† $0 copayment for each Medicare-covered exam.†† You will pay the cost-sharing that applies to specialist services (as described under "Physician/practitioner services, including doctor's office visits" above).††

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) – 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 (ESRD) related visits for home dialysis enrollees in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home – Telehealth services to diagnose, evaluate, or treat symptoms of a stroke – Telehealth services for enrollees with a substance use disorder or co-occurring mental health disorder **This benefit is continued on the next page**	You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you receive services.†† $0 copayment for primary care provider services or, in certain circumstances, nurse practitioner, physician's assistant or other non-physician health care professional services.†† $0 copayment for specialist physician services.†† **Out-of-Network** $0 copayment or 30% coinsurance for services from a primary care physician or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a primary care physician's office (as allowed by Medicare). You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: – you have an in-person visit within 6 months prior to your first telehealth visit – you have an in-person visit every 12 months while receiving these telehealth services – exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers. • Virtual check-ins (for example, by phone or video chat) with your doctor for 5–10 minutes **if** – you're not a new patient **and** – the check-in isn't related to an office visit in the past 7 days **and** – the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: – you're not a new patient and – the evaluation isn't related to an office visit in the past 7 days **and** – the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment **This benefit is continued on the next page**	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. $0 copayment or 30% coinsurance for services from a specialist or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a specialist's office (as allowed by Medicare). You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% coinsurance for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum. You will pay the cost-sharing that applies to a Medicare-covered in-office visit.

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery • Non-routine dental care. Covered services are limited to: – surgery of the jaw or related structures – setting fractures of the jaw or facial bones – pulling teeth before radiation treatments of neoplastic cancer – 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. • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Medicare-covered remote monitoring services • Monitoring services in a physician's office or outpatient hospital setting if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as "Coumadin Clinic" services) **This benefit is continued on the next page**	You will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you receive services. 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.

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) • 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 • Certain telehealth services, including: – Additional Virtual Medical Visits: – Urgently Needed Services – Primary Care Provider – Specialist – Other Health Care Professionals • Other types of Virtual Medical Visits: – Cardiac Rehabilitation Services – Intensive Cardiac Rehabilitation Services – Outpatient Rehabilitation Services – Physical Therapy and Speech-Language Therapy Please note that virtual visits may require video-enabled smartphone or other device. Not for use in emergencies. Not all network providers offer virtual care.	

Services that our plan pays for	What you must pay
Podiatry services We pay for the following services: • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for enrollees with conditions affecting the legs, such as diabetes	**In-Network** $0 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. **Out-of-Network** $0 copayment or 30% coinsurance 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.
Podiatry Services (Additional Routine Foot Care) We cover 4 in and out-of-network routine foot care visits every year. This benefit is in addition to the Medicare covered podiatry services benefit listed above. Covered services include treatment of the foot which is generally considered preventive, i.e., cutting or removal of corns, warts, calluses or nails.	**In-Network** $0 copayment for each routine visit. **Out-of-Network** 30% coinsurance for each routine visit.*

Services that our plan pays for	What you must pay
Prescription drugs (Outpatient) These drugs are covered under Part B of Original Medicare. Enrollees 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 • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens (for allergy shots) • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as EpogenR, ProcritR, Epoetin Alfa, AranespR, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Chemotherapy Drugs, and the Administration of chemotherapy **This benefit is continued on the next page**	$0, Medicare-covered Part B drug.[††]

Services that our plan pays for	What you must pay
Prescription drugs (Outpatient) (continued) You or your doctor may need to provide more information about how a Medicare Part B prescription drug is used in order to determine coverage. If you are prescribed a new medication or have not recently filled the medication under Part B, you may be required to try one or more of these other drugs before the plan will cover your drug. If you have already tried other drugs or your doctor thinks they are not right for you, you or your doctor can ask the plan to cover this drug. (For more information, see **Chapter 9**, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).) Please contact Enrollee Services for more information. We also cover some vaccines under our Part B and Part D prescription drug benefit. **Chapter 5** explains the Part D and DC Medicaid prescription drug benefit, including rules you must follow to have prescriptions covered.	

Services that our plan pays for	What you must pay
Prostate cancer screening exams For men age 50 and over, we pay for the following services once every 12 months: • A digital rectal exam • A prostate specific antigen (PSA) test	**In-Network** There is no coinsurance, copayment, or deductible for each Medicare-covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test. **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered digital rectal exam. You pay these amounts until you reach the out-of- pocket maximum. $0 copayment or 30% coinsurance for an annual PSA test. You pay these amounts until you reach the out-of-pocket maximum. Diagnostic PSA exams are subject to cost sharing as described under Outpatient diagnostic tests and therapeutic services and supplies in this chart.

Services that our plan pays for	What you must pay
Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here: • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.	**In-Network** $0 copayment for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices and related supplies.†† **Out-of-Network** $0 copayment or 30% for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices and related supplies. You pay these amounts until you reach the out-of-pocket maximum.
Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for enrollees who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	**In-Network** $0 copayment for each Medicare-covered pulmonary rehabilitative vist.†† **Out-of-Network** $0 copayment or 30% for each Medicare-covered pulmonary rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STI's and counseling for STI's preventive benefit. **Out-of-Network** $0 copayment or 30% coinsurance for the Medicare-covered screening for STI's and counseling for STI's preventive benefit. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Skilled nursing facility (SNF) care We pay for the following services, and maybe other services not listed here: • A semi-private room, or a private room if it is medically necessary • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood clotting factors • Blood, including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered SNF stay, 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. **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered SNF stay, up to 100 days. You pay these amounts until you reach the out-of-pocket maximum. You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines.

Services that our plan pays for	What you must pay
Skilled nursing facility (SNF) care (continued) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	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.
Smoking and tobacco use cessation If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit: • We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-Network** $0 copayment or 30% coinsurance for the Medicare-covered smoking and tobacco use cessation preventive benefits. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Supervised exercise therapy (SET) We pay for SET for enrollees with symptomatic peripheral artery disease (PAD). Our plan pays for: • Up to 36 sessions during a 12-week period if all SET requirements are met • An additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise training program for PAD in enrollees with leg cramping due to poor blood flow (claudication) • In a hospital outpatient setting or in a physician's office • Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	**In-Network** $0 copayment for each Medicare-covered supervised exercise therapy (SET) visit.†† **Out-of-Network** $0 copayment or 30% coinsurance for the Medicare-covered exercise therapy (SET) visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Urgently needed care Urgently needed care is care given to treat: • A non-emergency that requires immediate medical care, **or** • A sudden medical illness, **or** • An injury, **or** • A condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider because given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency). 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.	$0 copayment for each visit. $0 copayment for worldwide coverage of urgently needed services received outside of the United States. Please see **Chapter 7, Section A** for expense reimbursement for worldwide services.

Services that our plan pays for	What you must pay
Vision care We pay for: • One routine eye exam (eye refraction) each year • One pair of eyeglasses every 2 years unless: – A change of at least+/- 0.50 Diopters from the prior prescription; – A change of at least= 0.75 Sphere or- 0.50 Sphere, 0.50 Cylinder, ~prism diopter vertical, or 3 prism diopter lateral; – There has been a major change in visual acuity documented by a licensed optometrist; – The frames or lenses have been lost or broken beyond repair; **or** – A separate pair of readers is preferred to bifocals. • Contacts, limited to two boxes (one per eye) in a 6 month period All medically necessary repairs and replacements are covered, including eyeglasses, any vision device/lens, or repairs/replacements to the actual eye. We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered exam.†† $0 copayment for Medicare-covered glaucoma screening. $0 copayment for Medicare-covered eye exams to evaluate for eye disease.†† $0 copayment for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery. **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% coinsurance for Medicare-covered glaucoma screening. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% coinsurance for Medicare-covered eye exams to evaluate for eye disease. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
Vision care (continued) For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • People with a family history of glaucoma • People with diabetes • African-Americans who are age 50 and over • Hispanic Americans who are 65 and over We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. Covered eyeglasses after cataract surgery includes stand frames and lenses as defined by Medicare; any updates are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating).	$0 copayment or 30% coinsurance for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery. You pay these amounts until you reach the out-of-pocket maximum.

Services that our plan pays for	What you must pay
“Welcome to Medicare” preventive visit We cover the one-time “Welcome to Medicare” preventive visit. The visit includes: • A review of your health, • Education and counseling about the preventive services you need (including screenings and shots), **and** • Referrals for other care if you need it. 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:** We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.	**In-Network** There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit. There is no coinsurance, copayment, or deductible for a one-time Medicare-covered EKG screening if ordered as a result of your “Welcome to Medicare” preventive visit. Please refer to outpatient diagnostic tests and therapeutic services and supplies for other EKG’s. **Out-of-Network** $0 copayment or 30% coinsurance for the “Welcome to Medicare” preventive visit. You pay these amounts until you reach the outof-pocket maximum. $0 copayment or 30% coinsurance for a onetime 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. You pay these amounts until you reach the out-of-pocket maximum.

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

*Authorization rules may apply.

Section D1 DC Medicaid's Elderly and Persons with Physical Disability (EPD) Waiver Program

When given a choice, many seniors and adults with disabilities prefer to stay in familiar surroundings, which is often their own home. The Elderly and Persons with Physical Disabilities (EPD) Waiver Program is here to make this possible. This program provides services to help qualified older adults and persons with disabilities live in their own home or another place in the community instead of living in a nursing home. If you think you may meet the criteria described below (or you have already had an assessment completed and know you are eligible for the EPD Waiver), contact your case manager or care navigator for assistance applying for EPD Waiver benefits.

To be eligible for the EPD Waiver, you must:

- Be a resident of the District of Columbia
- Be a U.S. Citizen or hold legal immigration status
- Be eligible to receive DC Medicaid, with an income of less than 300% SSI or be eligible for Spend Down
- Have no more than $4,000 in countable assets
- Require assistance with activities of daily living
- Meet the "level of care" established for the Waiver

The EPD Waiver offers a combination of in-home or community-based support services, which include:

- Case management: assistance with obtaining or coordinating health care services
- Personal care aide services (PCA): assistance with activities of daily living, such as dressing, eating, toileting, etc.
- Personal Emergency Response System (PERS): an electronic system that allows people to call for assistance when needed
- Adult day health programs: non-residential services and supports promoting community inclusion and community-based care
- Respite care: assistance with daily needs when a primary caregiver is absent or unavailable
- Assisted living: a licensed residence with services and supports to allow participants to live independently
- Environmental accessibility adaptations: physical modifications to a home to ensure the safety and welfare of a resident

- Participant-directed services: more choice and flexibility over the services you receive, including personal care aide services

Section E Benefits covered outside of our plan

We don't cover the following services, but they are available through Medicare or DC Medicaid.

Section E1 Hospice care

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

Refer to the Medical Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

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

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

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

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

For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your **Enrollee Handbook**.

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

Section E2 DC Department of Behavioral Health (DBH) Services

Some behavioral health services are not covered by this program, but are available to you through the DC Department of Behavioral Health, including:

- Community-Based Interventions

- Mutli-Systemic therapy (MST)
- Assertive community treatment (ACT)
- Transitional assertive community treatment (TACT)
- Community support
- Recovery support services
- Vocational supported employment
- Clubhouse services
- Trauma recovery empowerment model (TREM)
- Trauma systems therapy (TST)
- Functional family therapy (FFT)
- Outpatient rehabilitation services

Section F Benefits not covered by our plan, Medicare, or DC Medicaid

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medicaid do not pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this **Enrollee Handbook**) except under specific conditions listed. If you get the services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your **Enrollee Handbook**.

In addition to any exclusions or limitations described in the Medical Benefits Chart, our plan does not cover the following items and services:

- Services considered not "reasonable and medically necessary", according to Medicare and DC Medicaid standards, unless we list these as covered services
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of your **Enrollee Handbook** for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.

- Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- A private room in a hospital, except when medically necessary
- Personal items in your room at a hospital or a nursing facility, such as a telephone or television
- Fees charged by your immediate relatives or members of your household
- Meals delivered to your home
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- Chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Radial keratotomy, LASIK surgery, and other low-vision aids
- Reversal of sterilization procedures and non-prescription contraceptive supplies
- Naturopath services (the use of natural or alternative treatments)
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.
- Equipment or supplies that condition the air and other primarily non-medical equipment
- Immunizations for foreign travel purposes
- Abortions (exceptions include rape, incest or danger to mother's life)
- Experimental drugs
- Infertility treatment
- Clinical trial protocol services
- 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
- Phone calls, newspapers, movie rentals and gift cards
- Expenses for lodging when staying with a relative or friend
- Meals

Chapter 5

Getting your outpatient prescription drugs

Chapter 5

Getting your outpatient prescription drugs

Introduction

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

We also cover the following drugs, although they are not discussed in this chapter:

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

Rules for our plan's outpatient drug coverage

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

We usually cover your drugs as long as you follow the rules in this section. You must have a doctor or other provider write your prescription, which must be valid under applicable District law. This person often is your primary care provider (PCP).

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists or any similar Medicaid lists.

You generally must use a network pharmacy to fill your prescription.

Your prescribed drug must be on our plan's **List of Covered Drugs**. We call it the "Drug List" for short.

- If it is not on the "Drug List," we may be able to cover it by giving you an exception.
- Refer to **Chapter 9** to learn about asking for an exception.

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

references. Your doctor may be able to help identify medical references to support the requested use of the prescribed drug.

Section A Getting your prescriptions filled

Section A1 Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan enrollees. You may use any of our network pharmacies.

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

Section A2 Using your enrollee UCard when you fill a prescription

To fill your prescription, **show your enrollee UCard** at your network pharmacy. The network pharmacy bills us for your covered prescription drug.

If you do not have your Enrollee UCard with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back. **If you can't pay for the drug, contact Enrollee Services right away.** We will do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of your **Enrollee Handbook**.
- If you need help getting a prescription filled, contact Enrollee Services or your care coordinator.

Section A3 What to do if you change your network pharmacy

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

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

Section A4 What to do if your pharmacy leaves the network

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

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

Section A5 Using a specialized pharmacy

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

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

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

Section A6 Using mail-order services to get your drugs

Our plan's mail-order service requires you to order **a 90-day supply**. A 100-day supply has the same copay as a three-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, 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 prescription arrives within ten business days. However, sometimes your mail-order may be delayed. If your mail-order is delayed, please follow these steps:

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

Mail-order processes

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

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

   The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets from your provider's office**

   The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

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

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

   If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

   - This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before it is shipped.
   - Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

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

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

   For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

   - The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
   - If you choose not to use our auto refill program, contact your pharmacy 10 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by phone or mail.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping.

Section A7 Getting a long-term supply of drugs

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

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 100-day supply has the same copay as a three-month supply. The **Provider and Pharmacy Directory** tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call your care coordinator or Enrollee Services for more information.

You can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Optum Home Delivery is a service of Optum Rx, a home delivery pharmacy, pharmacy benefit manager and affiliate of UnitedHealthcare Insurance Company. You are not required to use Optum Rx for your maintenance medications. Other pharmacies are available in your network. Refer to **Section A6** to learn about mail-order services.

Section A8 Using a pharmacy not in our plan's network

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

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

- **Prescriptions for a Medical Emergency**

  We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Formulary without restrictions, and are not excluded from Medicare Part D coverage.

- **Coverage when traveling or out of the service area**

  If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network preferred mail service pharmacy or through our other network pharmacies. Contact Enrollee Services to find out about ordering your prescription drugs ahead of time.

- If you are traveling within the United States and become ill or run out of or lose your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules.
- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy is not within reasonable driving distance that provides 24-hour service.
- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or network preferred mail-order pharmacy (including high cost and unique drugs).
- If you need a prescription while a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.

In these cases, check with your care coordinator or Enrollee Services first to find out if there's a network pharmacy nearby.

Section A9 Paying you back for a prescription

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

To learn more about this, refer to **Chapter 7** of your **Enrollee Handbook**.

Section B Our plan's "Drug List"

We have a **List of Covered Drugs**. We call it the "Drug List" for short.

We select the drugs on the "Drug List" with the help of a team of doctors and pharmacists. The "Drug List" also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's "Drug List" when you follow the rules we explain in this chapter.

Section B1 Drugs on our "Drug List"

Our "Drug List" includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under DC Medicaid.

Our "Drug List" includes brand name drugs, generic drugs, and biosimilars.

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 our "Drug List", when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternative that are called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name drugs or biological products and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs. There are biosimilar alternatives for some biological products. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Enrollee Services.

Section B2 How to find a drug on our "Drug List"

To find out if a drug you take is on our "Drug List", you can:

- Check the most recent "Drug List" we sent you in the mail.
- Visit our plan's website at **myuhc.com/CommunityPlan**. The "Drug List" on our website is always the most current one.
- Call your care coordinator or Enrollee Services to find out if a drug is on our "Drug List" or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at **myuhc.com/CommunityPlan** or call your care coordinator or Enrollee Services. With this tool you can search for drugs on the "Drug List" to get an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

Section B3 Drugs not on our "Drug List"

We don't cover all prescription drugs. Some drugs are not on our "Drug List" because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our "Drug List."

Our plan does not pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your **Enrollee Handbook** for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and DC Medicaid drugs) cannot pay for a drug that Medicare Part A or Medicare Part B already covers. Our

plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.

2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or DC Medicaid cannot cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms, except single-agent medications prescribed by a licensed provider
- Drugs used for cosmetic purposes or to promote hair growth, unless medically necessary
- Prescription vitamins and mineral products, except certain single-agent, prenatal, or geriatric vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction, unless medically necessary
- Drugs used for the treatment of anorexia, weight loss or weight gain, unless included on the District Medicaid Preferred "Drug List" and the Pharmacy Billing Manual and prescribed by a licensed provider
- Outpatient drugs made by a company that says you must have tests or services done only by them
- Non-prescription drugs (also called over-the-counter drugs)

Section C Limits on some drugs

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

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

To learn more about asking for exceptions, refer to **Chapter 9** of your **Enrollee Handbook**.

1. **Limiting use of a brand name drug or original biolgical products when a generic or interchangeable biosimilar. version is available**

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

   - We usually will not pay for the brand name drug or original biological product when there is a generic version.
   - However, if your provider has told us the medical reason that the generic drug or interchangeable biosimilar will not work for your or has written "No Substitutions" on your prescription for a brand name drug or original biological product or has told us the medical reason that neither the generic drug, interchangeable biosimilar nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

2. **Getting plan approval in advance**

   For some drugs, you or your doctor must get approval from our plan before you fill your prescription. If you don't get approval, we may not cover the drug. This is called "prior authorization." This is put in place to ensure medication safety and help guide appropriate use of certain drugs.

3. **Trying a different drug first**

   In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

   If Drug A does **not** work for you, then we cover Drug B. This is called step therapy.

4. **Quantity limits**

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

To find out if any of the rules above apply to a drug you take or want to take, check our "Drug List". For the most up-to-date information, call Enrollee Services or check our website at **myuhc.com/CommunityPlan**. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of the **Enrollee Handbook**.

Section D Reasons your drug might not be covered

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

- Our plan doesn't cover the drug you want to take. The drug may not be on our "Drug List." We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

Section D1 Getting a temporary supply

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

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

1. The drug you've been taking:
   - Is no longer on our "Drug List" **or**
   - Was never on our "Drug List" **or**
   - Is now limited in some way.
2. You must be in one of these situations:
   - You were in our plan last year.
     - We cover a temporary supply of your drug **during the first 90 days of the calendar year.**
     - This temporary supply is for up to 30 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
   - You are new to our plan.
     - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan**.

- This temporary supply is for up to 30 days.
- If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

• You have been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.

- We cover one 30-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
- 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.

Section D2 Asking for a temporary supply

To ask for a temporary supply of a drug, call Enrollee Services.

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

• Change to another drug.

Our plan may cover a different drug that works for you. Call Enrollee Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

OR

• Ask for an exception.

You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our "Drug List" or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

Section D3 Asking for an exception

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

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

To learn more about asking for an exception, refer to **Chapter 9** of your **Enrollee Handbook**.

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

Section E Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our "Drug List" during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

For more information on these drug rules, refer to **Section C.**

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

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

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

- Check our current "Drug List" online at **myuhc.com/CommunityPlan or**
- Call Enrollee Services at the number at the bottom of the page to check our current "Drug List."

Some changes to our "Drug List" happen **immediately**. For example:

- **A new generic drug becomes available.** Sometimes, a new generic drug or interchangeable biosimilar version of the same biological product comes on the market that works as well as a brand name drug on our "Drug List" now. When that happens, we may remove the brand name drug or original biological product and add the new generic drug or interchangeable biosimilar version of the same biological product, but your cost for the new drug stays the same.

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

  - We may not tell you before we make this change, but we send you information about the specific change we made once it happens. 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 provider can ask for an "exception" from these changes. We send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of your **Enrollee Handbook** for more information on exceptions.
- **A drug is taken off the market.** If the Food And Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we take it off the "Drug List." If you are taking the drug, we tell you. Your prescriber will know about this change and can work with you to find another drug for your condition.

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

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

When these changes happen, we:

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

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

- If there is a similar drug on our "Drug List" you can take instead **or**
- If you should ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9** of your **Enrollee Handbook**.

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

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

Section F Drug coverage in special cases

Section F1 In a hospital or a skilled nursing facility for a stay that our plan covers

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

Section F2 In a long-term care facility

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

Check your **Provider and Pharmacy Directory** to find out if your long-term care facility's pharmacy is part of our network. If it is not or if you need more information, contact Enrollee Services. If your 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.

Section F3 In a Medicare-certified hospice program

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

- If you are enrolled in a Medicare hospice and require certain drugs (e.g., a pain medication, anti-nausea drugs, laxative, or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of your **Enrollee Handbook** for more information about the hospice benefit.

Section G Programs on drug safety and managing drugs

Section G1 Programs to help you use drugs safely

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

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

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

Section G2 Programs to help you manage your drugs

Our plan has a program to help enrollees with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

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

Then, they will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.

- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

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

If you have questions about these programs, contact Enrollee Services or your care coordinator.

Section G3 Drug management program for safe use of opioid medications

Our plan has a program that can help enrollees safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

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

- Requiring you to get all prescriptions for those medications from certain pharmacies and/or from certain doctors.
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we 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 provider or pharmacy.

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

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an

appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of your **Enrollee Handbook**.)

The DMP may not apply to you if you:

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

Chapter 6

What you pay for your Medicare and DC Medicaid prescription drugs

Chapter 6

What you pay for your Medicare and DC Medicaid prescription drugs

Introduction

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

- Medicare Part D prescription drugs, **and**
- Drugs and items covered under Medicaid

Because you are eligible for DC Medicaid you get "Extra Help" from Medicare to help pay for your Medicare Part D prescription drugs.

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

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

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

- Our **List of Covered Drugs**.
  - We call this the "Drug List." It tells you:
    - Which drugs we pay for
    - If there are any limits on the drugs
  - If you need a copy of our "Drug List", call Enrollee Services. You can also find the most current copy of our "Drug List" on our website at **myuhc.com/CommunityPlan**.
- **Chapter 5** of your **Enrollee Handbook**.
  - It tells how to get your outpatient prescription drugs through our plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.
  - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is provided in "real time" meaning the cost displayed 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 call your care coordinator or Enrollee Services for more information.

- Our **Provider and Pharmacy Directory**.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - **The Provider and Pharmacy Directory** lists our network pharmacies. Refer to **Chapter 5** of your **Enrollee Handbook** more information about network pharmacies.

Section A The Explanation of Benefits (EOB)

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

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

When you get prescription drugs through our plan, we send you a summary called the **Explanation of Benefits**. We call it the EOB for short. The EOB is not a bill. The EOB has more information about the drugs you take. The EOB includes:

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

We offer coverage of drugs not covered under Medicare.

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

Section B How to keep track of your drug costs

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

1. **Use your Enrollee UCard.**

   Show your Enrollee UCard every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

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

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

If you have questions, please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free.
For more information, visit **myuhc.com/CommunityPlan**.

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

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

For more information about asking us to pay you back for a drug, refer to **Chapter 7** of your **Enrollee Handbook**.

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

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

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

   When you get an EOB in the mail, make sure it is complete and correct.

   - **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
   - **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

For more information, you can call UHC Dual Choice DC-S001 (PPO D-SNP)Enrollee Services or read the UHC Dual Choice DC-S001 (PPO D-SNP) **Enrollee Handbook**. For more information, you can access the **Enrollee Handbook** at our website **myuhc.com/CommunityPlan**.

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at UHC Dual Choice DC-S001 (PPO D-SNP) Enrollee Services. You can also find answers to many questions on our website: **myuhc.com/CommunityPlan**.

What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at UHC Dual Choice DC-S001 (PPO D-SNP) Enrollee Services.
- Or call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.

- You may also call the DC Department of Health Care Finance's Fraud Hotline at **1-877-632-2873** to report suspected Medicaid fraud.

If you think something is wrong or missing, or if you have any questions, call Enrollee Services. Keep these EOBs. They are an important record of your drug expenses.

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

With our plan, you pay nothing for covered drugs as long as you follow our rules.

Section C1 Getting a long-term supply of a drug

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

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

Section D Vaccinations

Important Message About What You Pay for Vaccines: Some vaccines are considered medical benefits. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's **List of Covered Drugs (Formulary)**. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's **List of Covered Drugs (Formulary)** or contact Enrollee Services for coverage and cost sharing details about specific vaccines.

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

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

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

We recommend that you call Enrollee Services if you plan to get a vaccination.

We can tell you about how our plan covers your vaccination

Chapter 7

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

Chapter 7

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

Introduction

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

Section A Asking us to pay for your services or drugs

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

We do not allow UHC Dual Choice DC-S001 (PPO D-SNP) providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for the full cost of health care or drugs, do not pay the bill and send the bill to us. To send us a bill, refer to **Section B**.

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid, it is your right to be paid back.
- If you paid for services covered by Medicare, we will pay you back.
- If you paid for services covered by DC Medicaid that are not covered by this program (for example, some community-based behavioral health services) we can't pay you back, but the provider will. Enrollee Services or your care coordinator can help you contact the provider's office. Refer to the bottom of the page for the Enrollee Services phone number.
- If we do not cover the services or drugs, we will tell you.

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

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

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

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
     - If the provider should be paid, we will pay the provider directly.
     - If you already paid for the Medicare service, we will pay you back.

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

   Network providers must always bill us. It's important to show your enrollee UCard when you get any services or prescriptions. But sometimes they make mistakes, and ask you to pay

for your services or more than your share of the costs. **Call Enrollee Services** or your care coordinator at the number at the bottom of this page **if you get any bills**.

- Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. **If you are retroactively enrolled in our plan**

   Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

   - If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
   - Send us the bill and proof of any payment you made.

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

   If you use an out-of-network pharmacy, you pay the full cost of your prescription.

   - In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
   - Refer to **Chapter 5** of your **Enrollee Handbook** to learn more about out-of-network pharmacies.

5. **When you pay the full prescription cost because you don't have your enrollee UCard with you**

   If you don't have your enrollee UCard with you, you can ask the pharmacy to call us or look up your plan enrollment information.

   - If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your enrollee UCard.
   - Send us a copy of your receipt when you ask us to pay you back.

6. **When you pay the full prescription cost for a drug that's not covered**

   You may pay the full prescription cost because the drug isn't covered.

   - The drug may not be on our **List of Covered Drugs** ("Drug List") on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug immediately, you may need to pay the full cost.

  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your **Enrollee Handbook**).
  - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your **Enrollee Handbook**).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your **Enrollee Handbook**.

Section B Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services or call us. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You can ask your care coordinator for help. You must submit your medical or Medicaid over the counter prescription claim to us within 12 months of the date you received the service, item, or drug. You must submit your prescription drug claim to us within 36 months of the date you received the service, item, or drug.

To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website (**myuhc.com/CommunityPlan**), or you can call Enrollee Services and ask for the form.

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

United Healthcare Dual Complete (PPO D-SNP)
P.O. Box 5280
Kingston, NY 12402

Section C Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay for it. If you already paid for the service or drug, we will mail you a check for what you paid. If you haven't paid, we will pay the provider directly.

Chapter 3 of your **Enrollee Handbook** explains the rules for getting your services covered.

Chapter 5 of your **Enrollee Handbook** explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9**.

Section D Appeals

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

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of your **Enrollee Handbook**:

- To make an appeal about getting paid back for a health care service, refer to **Section F**.
- To make an appeal about getting paid back for a drug, refer to **Section G**.

Chapter 8

Your rights and responsibilities

Chapter 8

Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as an enrollee of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of your **Enrollee Handbook**.

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

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

- To get information in a way that you can understand, call your care coordinator or Enrollee Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call Enrollee Services or write to:

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

  1-866-242-7726, TTY **711**

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 Enrollee Services or your care coordinator.
- To keep your information as a standing request for future mailings and communications please reach out to your care coordinator or call Enrollee Services.
- To change your standing request for preferred language and/or format please reach out to your care manager or call Enrollee Services.

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

- Medicare at **1-800-MEDICARE (1-800-633-4227)**. You can call 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- Medicaid Dual Choice support at **1-202-442-9533**. TTY users should call **711**.
- Office for Civil Rights at **1-800-368-1019**. TTY users should call **1-800-537-7697**.

Section B Our responsibility for your timely access to covered services and drugs

You have rights as an enrollee of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your **Enrollee Handbook**.
  - Call your care coordinator or Enrollee Services or look in the **Provider and Pharmacy Directory** to learn more about network providers and which doctors are accepting new patients.
- **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 10** tells what you can do.
- You have the right to a women's health specialist without getting a referral. We do **not** require you to get referrals.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your **Enrollee Handbook**.
- You have the right to know that when you talk with your doctors and other providers it's private.
- You have the right to have an illness or treatment explained to you in a language you can understand.
- You have the right to participate in decisions about your care, including the right to refuse treatment.

- You have the right to receive a full, clear, and understandable explanation of treatment options and risks of each option so you can make an informed decision.
- You have the right to refuse treatment or care.
- You have the right to see and receive a copy of your medical records and request an amendment or change, if incorrect.
- You have the right to be free from any form of restraints or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- You have the right to receive access to health care services that are available and accessible to you in a timely manner.
- You have the right to choose an eligible PCP/PDP from within UHC Dual Choice DC-S001 (PPO D-SNP)'s network and to change your PCP/PDP.
- You have the right to make a grievance about the care provided to you and receive an answer.
- You have the right to request an appeal or a fair hearing if you believe UHC Dual Choice DC-S001 (PPO D-SNP)'s was wrong in denying, reducing, or stopping a service or item.
- You have the right to receive Family Planning Services and supplies from the provider of your choice.
- You have the right to obtain medical care without unnecessary delay.
- You have the right to receive a second opinion from a qualified health care professional within the network, or, if necessary, to obtain one outside the network, at no cost to you.
- You have the right to receive information on Advance Directives and choose not to have or continue any life sustaining treatment.
- You have the right to receive a copy of UHC Dual Choice DC-S001 (PPO D-SNP)'s Provider Directory.
- You have the right to continue treatment you are currently receiving until you have a new treatment plan.
- You have the right to receive interpretation and translation services free of charge.
- You have the right to refuse oral interpretation services.
- You have the right to receive transportation services free of charge.
- You have the right to get an explanation of prior authorization procedures.
- You have the right to receive information about UHC Dual Choice DC-S001 (PPO D-SNP)'s financial condition and any special ways we pay our doctors.

- You have the right to obtain summaries of customer satisfaction surveys.
- You have the right to receive UHC Dual Choice DC-S001 (PPO D-SNP)'s "Dispense as Written" policy for prescription drugs.
- You have the right to receive a list of all covered drugs.
- You have the right to be treated with respect and due consideration for your dignity and right to privacy.
- You have the right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

Chapter 9 of your **Enrollee Handbook** tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

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

We protect your PHI as required by federal and District laws.

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

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

Section C1 How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. **If we do, we must get written permission from you first.** You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.

- We must give Medicare and DC Medicaid your PHI. If Medicare or DC Medicaid releases your PHI for research or other uses, they do it according to federal laws.

Section C2 Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. We may charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others.

If you have questions or concerns about the privacy of your PHI, call Enrollee Services.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

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

Effective January 1, 2022.

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

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

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

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

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

How We Collect, Use, and Share Your Information

We collect, use, and share your HI with:

- You or your legal representative.
- Government agencies.

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

- **For Payment.** We may collect, use, and share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may collect, use, and share your HI with your providers to help with your care.
- **For Health Care Operations.** We may suggest a disease management or wellness program. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** We may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.

- **For Underwriting Purposes.** We may collect, use, and share your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may collect, use, and share your HI to send you appointment reminders and information about your health benefits.
- **For Communications to You.** We may send you emails with certain health information via unencrypted methods. There is some risk of disclosure or interception of the contents of these communications.

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

- **As Required by Law.**
- **To Persons Involved with Your Care.** This may be to a family member in an emergency. This may happen if you are unable to agree or object. If you are unable to object, we will use our best judgment. If permitted, after you pass away, we may share HI with family members or friends who helped with your care.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings.** To answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.
- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.
- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** To study disease or disability.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death, or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.

- **To Our Business Associates** if needed to give you services. Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.
- **Other Restrictions.** Federal and District laws may further limit our use of the HI listed below. We will follow stricter laws that apply.
  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

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

Your Rights

You have the following rights.

- To ask us to limit use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy of certain HI.** You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. You can have your

record sent to a third party. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.

- **To ask to amend.** If you think your HI is wrong or incomplete you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website, (**myuhc.com/CommunityPlan**).

Using Your Rights

- **To Contact your Health Plan. Call the phone number on your enrollee UCard.** Or you may contact the Enrollee Services at **1-866-242-7726**, or TTY/RTT **711**.

Section D Our responsibility to give you information

As an enrollee of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Enrollee Services. This is a free service to you in other languages. We can also give you information in large print, braille, or audio also at no cost if you need it.

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

- How to choose or change plans
- Our plan, including:
  - Financial information
  - How plan enrollees have rated us
  - The number of appeals made by enrollees
  - How to leave our plan
- Our network providers and our network pharmacies, including:
  - How to choose or change primary care providers
  - Qualifications of our network providers and pharmacies

  - How we pay providers in our network
- Covered services and drugs, including:
  - Services (refer to **Chapters 3 and 4** of your **Enrollee Handbook**) and drugs (refer to **Chapters 5** of your **Enrollee Handbook**) covered by our plan
  - Limits to your coverage and drugs
  - Rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your **Enrollee Handbook**), including asking us to:
  - Put in writing why something is not covered
  - Change a decision we made
  - Pay for a bill you got

Section E Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of your **Enrollee Handbook**.

Section F Your right to leave our plan

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

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another MA plan.
- Refer to **Chapter 10** of your **Enrollee Handbook**:
  - For more information about when you can join a new MA or prescription drug benefit plan.
  - For information about how you will get your DC Medicaid benefits if you leave our plan.

Section G Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

Section G1 Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all 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 enrollees manage their medications and use drugs safely.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to.

  You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your **Enrollee Handbook** tells how to ask us for a coverage decision.

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

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

- Fill out a written form **giving someone the right to make health care decisions for you.**

- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do **not** want.

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

You are not required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Enrollee Services to ask for the forms.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Receive information on advance directives and choose not to have or continue any life-sustaining treatment.
- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

Call Enrollee Services for more information.

Section G3 What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with DC Health by calling **1-877-672-2174**, TTY **711**, Monday to Friday, 8:15 a.m.–4:45 p.m.

Section H Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of your **Enrollee Handbook** tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan enrollees have filed against us. Call Enrollee Services to get this information.

Section H1 What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly — and it is **not** about discrimination for reasons listed in **Chapter 11** of your **Enrollee Handbook** — or you want more information about your rights, you can call:

- Enrollee Services.
- The DC State Health Insurance Assistance Program (SHIP) program at **1-202-727-8370**. For more details about the DC SHIP, refer to **Chapter 2**.
- The Office of Health Care Ombudsman and Bill of Rights at **1-202-724-7491**. For more details about this program, refer to **Chapter 2** of your **Enrollee Handbook**.
- 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**. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at **medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.)
- Medicaid Dual Choice support at **1-202-442-9533**, Monday to Friday, 9 a.m.–4:45p.m. TTY users should call **711**.

Section I Your responsibilities as a plan enrollee

As a plan enrollee, you have a responsibility to do the things that are listed below. If you have any questions, call Enrollee Services.

- **Read the Enrollee Handbook** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your **Enrollee Handbook**. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5** of your **Enrollee Handbook**.

- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Enrollee Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are an enrollee of our plan. Show your enrollee UCard when you get services or drugs.
- **Treating those providing your care with respect and dignity.**
- **Following the rules** of the District Dual Choice Program and UHC Dual Choice DC-S001 (PPO D-SNP).
- **Going to scheduled appointments.**
- **Telling your doctor at least 24 hours before the appointment if you must cancel.**
- **Asking for more explanation** if you do not understand your doctor's instructions.
- **Going to the Emergency Room only if you have a medical emergency.**
- **Telling your PCP/PDP about medical and personal problems that may affect your health.**
- **Trying to understand your health problems and participate in developing treatment goals.**
- **Helping your doctor** in getting medical records from providers who have treated you in the past.
- **Telling UnitedHealthcare Community Plan if you were injured as the result of an accident or at work**
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan enrollees to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan enrollee, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most UHC Dual Choice DC-S001 (PPO D-SNP) enrollees, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free.
For more information, visit **myuhc.com/CommunityPlan**.

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- **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)

- **Tell us if you move.** If you plan to move, tell us right away. Call your care coordinator or Enrollee Services.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be enrollees of this plan. **Chapter 1** of your **Enrollee Handbook** tells about our service area.
  - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and DC Medicaid your new address when you move. Refer to **Chapter 2** of your **Enrollee Handbook** for phone numbers for Medicare and DC Medicaid.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
  - **Call your care coordinator or Enrollee Services for help if you have questions or concerns.**

Chapter 9

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

Chapter 9

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

Introduction

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

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

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

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

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints**; also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

Section A1 About the legal terms

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

For example, we say:

- "Making a complaint" instead of "filing a grievance"
- "Coverage decision" instead of "organization determination", "benefit determination", "at-risk determination", or "coverage determination"
- "Fast coverage decision" instead of "expedited determination"
- "Independent Review Organization" (IRO) instead of "Independent Review Entity" (IRE)

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

Section B Where to get help

Section B1 For more information and help

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

Help from the DC State Health Insurance Assistance Program (SHIP)

You can call the DC SHIP. DC SHIP counselors can answer your questions and help you understand what to do about your problem. DC SHIP is not connected with us or with any insurance company or health plan. DC SHIP has trained counselors and services are free. The DC SHIP phone number is **1-202-727-8370**.

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

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

Help and information from DC Medicaid Dual Choice Support

For more information you can contact DC Medicaid's Dual Choice Support line at **1-202-442-9533**, Monday–Friday, 9 a.m.–4:45 p.m. You can also email **DualChoice@dc.gov**.

Help from the Office of Health Care Ombudsman and Bill of Rights

You can contact the Ombudsman program at **1-202-724-7491**, Monday–Friday, 9 a.m.–4:45 p.m. You can also email **healthcareombudsman@dc.gov**.

Help from The Office of the DC Long-Term Care (LTC) Ombudsman

You can contact the LTC Ombudsman program at **1-202-434-2190** or by emailing **DCOmbuds@aarp.org**. Calls and emails are responded to within 24 hours or the next business day.

Section C Understanding Medicare and DC Medicaid complaints and appeals in our plan

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

Sometimes Medicare and DC Medicaid processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a DC Medicaid benefit. **Section F4** explains these situations.

Section D Problems with your benefits

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

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way in which they are covered, and problems related to payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to **Section E**, "Coverage decisions and appeals."	**No.** My problem is not about benefits or coverage. Refer to **Section K**, "How to make a complaint."

Section E Coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment).

Section E1 Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4**, **Section H** of your **Enrollee Handbook**.)

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what is covered for you and how much we pay.

In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or DC Medicaid. If you disagree with this coverage decision, you can make an appeal.

Section E2 Appeals

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

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 if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare medical service or item or Part B drugs, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

Section E3 Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Enrollee Services** at the numbers at the bottom of the page.
- DC State Health Insurance Assistance Program (SHIP) at **1-202-727-8370**.
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.

- Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

- **The Office of Health Care Ombudsman and Bill of Rights** at **1-202-724-7491**.
- **The Office of the DC Long-Term Care Ombudsman** at **1-202-434-2190**.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Enrollee Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting **cms.gov/Medicare/CMSForms/ CMS-Forms/downloads/cms1696.pdf** or on our website **myuhc.com/CommunityPlan**. **You must give us a copy of the signed form**.

Section E4 Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter.

Refer to the section that applies:

- **Section F**, "Medical care"
- **Section G**, "Medicare Part D prescription drugs"
- **Section H**, "Asking us to cover a longer hospital stay"
- **Section I**, "Asking us to continue covering certain medical services" (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Enrollee Services at the numbers at the bottom of the page. You can also get help or information from government organizations such as your State Health Insurance Program.

Section F Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of your **Enrollee Handbook**. We generally refer to "medical care coverage" or "medical care" in the rest of this section. The term "medical care" includes medical services and items as well as Medicare Part B prescription drugs which are drugs administered by your doctor or health care

professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

Section F1 Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.
   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

Section F2 Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **"integrated organization determination."**

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: **1-866-242-7726**, TTY: **711**.
- Faxing: **1-888-950-1169**

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free. For more information, visit **myuhc.com/CommunityPlan**.

- Writing:

  UnitedHealthcare Enrollee Services Department (Coverage Determination)
  P.O. Box 30769
  Salt Lake City, UT 84130-0769

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

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

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer about a:

- Medical service or item within 14 calendar days after we get your request.
- Medicare Part B prescription drug within 72 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can't take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.

Fast coverage decision

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

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can't take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You are asking for coverage for medical items and/or services that you **did not get**. You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, 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 you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal.

Appeals are discussed in the next section.

Section F3 Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at **1-866-242-7726**, TTY **711**.

Ask for a standard appeal or a fast appeal in writing or by calling us at **1-866-242-7726**.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting **cms.gov/Medicare/CMS-Forms/CMSForms/downloads/cms1696.pdf** or on our website at **myuhc.com/CommunityPlan**.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 60 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

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

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

If you have questions, please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free. For more information, visit **myuhc.com/CommunityPlan**.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.
  - If you do not appeal before these dates, then your service or item will not be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal.** We will give you our answer sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.

- If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.
- If your problem is about coverage of a Medicaid service or item, you can file a Level 2 — Fair Hearing with the District yourself as soon as the time is up. In the District, Fair Hearings are filed with District's Office of Administrative Hearings. You must request your Fair Hearing within 120 calendar days from the date of UHC Dual Choice DC-S001 (PPO D-SNP)'s Level 1 decision.
- If you want to continue receiving the benefit during your Fair Hearing or appeal, you must request the Fair Hearing within 10 calendar days from the postmark on UHC Dual Choice DC-S001 (PPO D-SNP)'s Appeal Resolution Notice or by the intended effective date of UHC Dual Choice DC-S001 (PPO D-SNP)'s proposed action (in other words, when the benefit is to stop) — whichever is later.
- To file a request for Fair Hearing, call **1-202-442-9094** or write to District of Columbia Office of Administrative Hearings, Clerk of the Court, 441 4th Street, NW, Room N450 Washington, DC 20001.

- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request**, we send your appeal to the IRO for a Level 2 Appeal. The IRO will notify you in writing when it receives your appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If you think we should **not** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.

- If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.
- If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the District yourself as soon as the time is up. In the District, Fair Hearings are filed with District's Office of Administrative Hearings. You must request your Fair Hearing within 120 calendar days from the date of UHC Dual Choice DC-S001 (PPO D-SNP)'s Level 1 decision.
- If you want to continue receiving the benefit during your Fair Hearing or appeal, you must request the Fair Hearing within 10 calendar days from the postmark on UHC Dual Choice DC-S001 (PPO D-SNP)'s Appeal Resolution Notice or by the intended effective date of UHC Dual Choice DC-S001 (PPO D-SNP)'s proposed action (in other words, when the benefit is to stop) — whichever is later.
- To file a request for Fair Hearing, call **1-202-442-9094** or write to District of Columbia Office of Administrative Hearings, Clerk of the Court, 441 4th Street, NW, Room N450 Washington, DC 20001.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a DC Medicaid service or item, the letter tells you how to file a Level 2 Appeal yourself.

Section F4 Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, DC Medicaid, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that DC Medicaid usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.

- If your problem is about a service or item that **both Medicare and** DC Medicaid may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the District.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by DC Medicaid, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity"**, sometimes called the **"IRE"**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The IRO 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 also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free.
For more information, visit **myuhc.com/CommunityPlan**.

- If your request is for a Medicare Part B prescription drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The IRO take extra time to make a decision if your request is for a Medicare Part B prescription drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO 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 1**4 calendar days** after we get the IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says Yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:**
  - **Within 72 hours** after we get the IRO's decision for **standard requests**, or
  - **Within 24 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says No to part or all of your appeal,** it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - 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.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that is covered by both Medicare and DC Medicaid

A Level 2 Appeal for services that DC Medicaid usually covers is a Fair Hearing with the District. In the District a Fair Hearing is filed with District's Office of Administrative Hearings. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision

letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

Section F5 Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

We can't reimburse you directly for a Medicaid service or item that is not covered by this program (for example, some community-based behavioral health services). If you get a bill for Medicaid covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to **Chapter 7** of your **Enrollee Handbook**.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you the payment for the service or item within 60 calendar days after we get your request.

- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the IRO. We will send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and DC Medicaid usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

Section G Medicare Part D prescription drugs

Your benefits as an enrollee of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that DC Medicaid may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time. For drugs covered only by Medicaid follow the process in **Section E** on page 8-6.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your **Enrollee Handbook** for more information about a medically accepted indication.

Section G1 Medicare Part D coverage decisions and appeals

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

- You ask us to make an exception, including asking us to:
  - Cover a Medicare Part D drug that is not on our plan's "Drug List" or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's "Drug List" but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our "Drug List" or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our "Drug List," and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4.**	Refer to **Section G4.**	Refer to **Section G4.**	Refer to **Section G5.**

Section G2 Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our "Drug List" or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that is not on our "Drug List"**
   - You can't get an exception to the required copay amount for the drug.

Section G3 Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

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

Our "Drug List" often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally do **not** approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

Section G4 Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling **1-866-242-7726**, TTY **711**, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your **Enrollee Handbook**.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

A "fast coverage decision" is called an **"expedited coverage determination."**

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer **within 72 hours** after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage **within 72 hours** after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Section G5 Making a Level 1 Appeal

An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination".**

- Start your **standard** or **fast appeal** by calling **1-866-242-7726**, TTY **711**, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 60 calendar day**s from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

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

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.

- If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Section G6 Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision. If, however, we did not complete our review with 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.

The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity"**, sometimes called the **"IRE"**.

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file.**
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **Within 7 calendar days** after they get your appeal for a drug you didn't get.
- **Within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought **within 30 calendar days** after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section H Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your **Enrollee Handbook**.

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

- The day you leave the hospital is called your **"discharge date."**
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

Section H1 Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called **"Important Message from Medicare."** Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Enrollee Services at the numbers at the bottom of the page. You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.

- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you're being discharged from the hospital too soon.

- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Enrollee Services at the numbers at the bottom of the page
- 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**.
- Visit **cms.gov/Medicare/Medicare-General-Information/BNI**.

Section H2 Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In the District, the QIO is Livanta BFCC-QIO. Call them at **1-888-396-4646**. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than midnight on the day of your planned discharge date.

- **If you call before you leave,** you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you do not call to appeal,** and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.

- **If you miss the deadline** for contacting the QIO about your appeal, appeal to our plan directly instead. Refer to **Section G4** for information about making an appeal to us.

Ask for help if you need it. If you have questions or need help at any time:

- Call Enrollee Services at the numbers at the bottom of the page.
- Call the DC State Health Insurance Assistance Program (SHIP) at **1-202-727-8370** .

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

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

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the "**Detailed Notice of Discharge**." You can get a sample by calling Enrollee Services at the numbers at the bottom of the page 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 refer to a sample notice online at **cms.gov/medicare/appeals-grievances/managed-care/notices-forms**.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- There may be limitations on your covered hospital services.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free. For more information, visit **myuhc.com/CommunityPlan**.

- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

Section H3 Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at **1-888-396-4646**.

You must ask for this review **within 60 calendar days** after the day the QIO 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.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- Coverage limitations may apply.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

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 written in the notice you get after your Level 2 appeal decision. An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section H4 Making a Level 1 Alternate Appeal

The deadline for contacting the QIO for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Enrollee Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

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

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for the costs of care you got since the date when we said your coverage would end. There may be limitations that apply.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

Section H5 Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the IRO within 24 hours of saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section I Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- Home health care services
- Skilled nursing care in a skilled nursing facility, **and**
- Rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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

Section I1 Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care.

This is called the "**Notice of Medicare Non-Coverage.**" The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

Section I2 Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Enrollee Services at the numbers at the bottom of the page.
  - Call the DC State Health Insurance Assistance Program (SHIP) at **1-202-727-8370**.
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of your **Enrollee Handbook** for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the **"Notice of Medicare Non-Coverage"** we sent you.
- If you miss the deadline for contacting the QIO, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4.**

The legal term for the written notice is "**Notice of Medicare Non-Coverage**". To get a sample copy, call Enrollee Services at the numbers at the bottom of the page or call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or get a copy online at **cms.gov/Medicare/Medicare-General-Information/BNI**.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage".**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.
- There may be limitations on your covered services.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

Section I3 Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at **1-888-396-4646**.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.
- There may be coverage limitations that apply.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section I4 Making a Level 1 Alternate Appeal

As explained in **Section I2**, you must act quickly and contact the QIO to start your Level 1 Appeal. If you miss the deadline, you can use an "Alternate Appeal" process.

Contact Enrollee Services at the numbers at the bottom of the page and ask us for a "fast review".

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

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.
- We agree to pay you back for the costs of care you got since the date when we said your coverage would end.
- There may be coverage limitations that apply.

If we say **No** to your fast appeal:

- Our coverage for these services ends on the date we told you.
- We will not pay any of the costs after this date.
- You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
- We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

Section I5 Making a Level 2 Alternate Appeal

During the Level 2 Appeal:

- We send the information for your Level 2 Appeal to the IRO within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.
- If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.
- The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end. There may be coverage limitations that apply.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section J Taking your appeal beyond Level 2

Section J1 Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.

- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

Section J2 Additional DC Medicaid appeals

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

Section J3 Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be appropriate for you if you 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 appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, 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 Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

Section K How to make a complaint

Section K1 What kinds of problems should be complaints

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

Complaint	Example
Quality of your medical care	• You are unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone did not respect your right to privacy or shared confidential information about you.

Complaint	Example
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our plan.
Accessibility and language assistance	• You cannot physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Enrollee Services, or other plan staff keep you waiting too long. – Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• You think the clinic, hospital or doctor's office is not clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call Enrollee Services at **1-866-242-7726** for internal complaints, and/or the Medicare at **1-800-MEDICARE (1-800-633-4227)** for external complaints.

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free.
For more information, visit **myuhc.com/CommunityPlan**.

The legal term for a "complaint" is a **"grievance."**

The legal term for "making a complaint" is **"filing a grievance."**

Section K2 Internal complaints

To make an internal complaint, call Enrollee Services at **1-866-242-7726**. You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there is anything else you need to do, Enrollee Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- When you file a complaint, we will address it as quickly as possible but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.
- If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. If we do not accept your complaint in the whole or in part, our written decision will explain why it was not accepted and will tell you about options you may have. The address and fax numbers for filing complaints are located in **Chapter 2** under "How to contact us when you are making a complaint about your medical care" OR "How to contact us when you are making a complaint about your Part D prescription drugs".
- **Whether you call or write, you should contact Enrollee Services right away.** You can make the complaint at any time after you had the problem you want to complain about.

The legal term for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.

- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

Section K3 External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at **medicare.gov/MedicareComplaintForm/home.aspx**. You do not need to file a complaint with UHC Dual Choice DC-S001 (PPO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan is not addressing your problem, you can also call **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**. The call is free.

Medicaid

You can tell Medicaid about your complaint by calling Dual Choice Support at **1-202-442-9533**. TTY users can dial **711**. You can also email **DualChoice@dc.gov**.

You can also file a complaint with the Office of Health Care Ombudsman and Bill of Rights by calling **1-202-724-7491**. TTY users can dial **711**.

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is **1-800-368-1019**. TTY users should call **1-800-537-7697**. You can visit **hhs.gov ocr** for more information.

You may also contact the local OCR office at:

HHS Headquarters
200 Independence Avenue, S.W.
Washington, D.C. 2020

You may also have rights under the Americans with Disability Act (ADA). You can contact the local OCR office.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of your **Enrollee Handbook**.

In the District, the QIO is called Livanta BFCC-QIO. The phone number for Livanta BFCC-QIO is **1-888-396-4646**.

Problems about your Medicaid benefits

Chapter 10

Ending your membership in our plan

Chapter 10

Ending your membership in the plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and DC Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your **Enrollee Handbook**.

Section A When you can end your membership in our plan

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

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

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You move out of our service area,
- Your eligibility for DC Medicaid or Extra Help changed, **or**
- If you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medicaid services in **Section C2**.

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

- Enrollee Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- The State Health Insurance Assistance Program (SHIP), DC SHIP at **1-202-727-8370**. TTY users should call **711**.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of your **Enrollee Handbook** for information about drug management programs.

Section B How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are three ways you can ask to be disenrolled:

- You can make a request in writing to us or visit our website to disenroll online. Contact Enrollee Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users (people who have difficulty with hearing or speaking) should call **1-877-486-2048**. When you call **1-800-MEDICARE**, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 9-4.
- Call the DC State Health Insurance Assistance Program (SHIP) at **1-202-727-8370**, TTY **711**. Section C below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

Section C How to get Medicare and DC Medicaid services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

Section C1 Your Medicare services

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	Here is what to do:
Another Medicare health plan	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**. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call **1-855-921-PACE (7223)**. If you need help or more information: • Call the DC State Health Insurance Assistance Program (SHIP), **1-202-727-8370**, TTY **711**, Monday–Friday, 9:30 a.m.–4:30 p.m. For more information, please visit **dacl.dc.gov/service/health-insurance-counseling**. **OR** Enroll in a new Medicare plan. You are automatically disenrolled from our Medicare plan when your new plan's coverage begins. Your entitlement to Medicaid is not affected by your choice of Medicare coverage. You will still be eligible for Medicaid, subject to any needed reevaluation, and your Medicaid services can continue in Medicaid Fee-for-Service.

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare prescription drug plan	Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the DC State Health Insurance Assistance Program (SHIP), **1-202-727-8370**, TTY **711**, Monday–Friday, 9:30 a.m.–4:30 p.m. For more information, please visit **dacl.dc.gov/service/health-insurance-counseling**. **OR** Enroll in a new Medicare prescription drug plan. You are automatically disenrolled from our plan when your Original Medicare coverage begins. Your entitlement to Medicaid is not affected by your choice of Medicare coverage. You will still be eligible for Medicaid, subject to any needed reevaluation, and your Medicaid services can continue in Medicaid Fee-for-Service.

3. You can change to:	Here is what to do:
Original Medicare without a separate Medicare prescription drug plan **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the DC SHIP at **1-202-727-8370**, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local SHIP office in your area, please visit **dacl.dc.gov/service/health-insurancecounseling**.	Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the DC State Health Insurance Assistance Program (SHIP), **1-202-727-8370**, TTY **711**, Monday–Friday, 9:30 a.m.–4:30 p.m. For more information, please visit **dacl.dc.gov/service/health-insurance-counseling**. You are automatically disenrolled from our plan when your Original Medicare coverage begins. Your entitlement to Medicaid is not affected by your choice of Medicare coverage. You will still be eligible for Medicaid, subject to any needed reevaluation, and your Medicaid services can continue in Medicaid Fee-for-Service.

Section C2 Your DC Medicaid services

When you change your enrollment in the Dual Choice program, both your Medicare and Medicaid coverage options change. If you choose to change your Medicare coverage to any of the options in **Chapter 10**, Section C1 above, you will be enrolled in Medicaid on a fee-for-service basis.

If you need help or more information about how to get your DC Medicaid services after you leave our plan, contact:

- The DC State Health Insurance Assistance Program (SHIP), **1-202-727-8370**, TTY **711**, Monday–Friday, 9:30 a.m.–4:30 p.m. For more information, please visit **dacl.dc.gov/service/health-insurance-counseling**.

Dual Choice Support at **1-202-442-9533**, TTY **711**, 9 a.m.–4:45 p.m., Monday–Friday, **dhcf.dc.gov/**.

Section D Your medical items, services and drugs until your membership in our plan ends

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

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in UHC Dual Choice DC-S001 (PPO D-SNP) ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

Section E Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Enrollee Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be an enrollee of our plan.
  - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain an enrollee on this basis.
  - We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other enrollees of our plan.
- If you let someone else use your enrollee UCard to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will dis-enroll you from our plan.

Section F Rules against asking you to leave our plan for any health-related reason

We cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

Section G Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of your **Enrollee Handbook** for information about how to make a complaint.

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

If you have questions or would like more information on ending your membership, you can call Enrollee Services at the number at the bottom of this page.

Chapter 11

Legal notices

Chapter 11

Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your **Enrollee Handboo**k.

Section A Notice about laws

Many laws apply to this **Enrollee Handbook**. These laws may affect your rights and responsibilities even if the laws are not included or explained in the **Enrollee Handbook**. The main laws that apply are federal laws about the Medicare and DC Medicaid programs. Other federal and District laws may apply too.

Section B Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, moral beliefs, 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. We must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at **1-800-368-1019**. TTY users can call **1-800-537-7697**. You can also visit **hhs.gov/ocr** for more information.
- Call your local Office for Civil Rights.

  U.S. Dept. of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- If you have a disability and need help accessing health care services or a provider, call Enrollee Services. If you have a complaint, such as a problem with wheelchair access, Enrollee Services can help.

Section C Notice about Medicare as a second payer and DC Medicaid as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and District laws and regulations relating to the legal liability of third parties for health care services to enrollees, including Section 1902(a)(25) of the Social Security Act, 42 C.F.R. Part 433, Subpart D, and the Health Care Assistance Reimbursement Act of 1984 (DC Law 5-86: DC, Code Section 3-501 et seq.). We take all reasonable measures to ensure that DC Medicaid is the payer of last resort.

Section D Third party liability and subrogation

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

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

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment, or verdict. You may be required

by us and you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

Section E Enrollee liability

In the event we fail to reimburse network providers' charges for covered services that are covered by both Medicare and Medicaid, you will not be liable for any sums owed by us.

You will be liable if you receive services from non-network providers without authorization. Neither the plan nor Medicare nor DC Medicaid 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 nor DC Medicaid will pay for those services.

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

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

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

5. At least as beneficial as an existing and available medically appropriate alternative.

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

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

Section H Acts beyond our control

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

Section I Contracting medical providers and network hospitals are independent contractors

The relationships between us and our network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of UnitedHealthcare Insurance Company or one of its affiliates.

An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare Insurance Company or one of its affiliates is an employee or agent of the network providers or network hospitals.

Section J Technology assessment

We regularly review new procedures, devices, and drugs to determine whether or not they are safe and efficacious for Enrollees. 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 enrollee 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 Enrollee, one of our Medical Directors makes a medical necessity determination based on individual Enrollee medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

Section K Enrollee 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 **Enrollee Handbook** or be used in defense of a legal action unless it is contained in a written application.

Section L Information upon request

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

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

Section M 2024 Enrollee fraud & abuse communication

2024 Enrollee Fraud & Abuse Communication

Fraud is a serious matter. What is fraud? Fraud is making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. An

example of fraud for enrollees is falsely claiming that you live in the District when you live outside the boundaries of the District of Columbia.

How you can fight health care fraud

Our company is committed to preventing fraud, waste, and abuse in Medicare and Medicaid 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 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.

If you suspect fraud or any other misuse of services, please let us know. It is not required that you identify yourself or give your name. If you would like more information about what fraud is, visit UnitedHealthcare Community Plan's website at **https://uhc.com/fraud**. To report fraud, call UnitedHealthcare Community Plan Compliance Hotline, **1-844-359-7736**, or call the DC Department of Health Care Finance's Fraud Hotline at **1-877-632-2873**.

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

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

Section N How our network providers are generally compensated

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.

Chapter 12

Definitions of important words

Introduction

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

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your **Enrollee Handbook** explains appeals, including how to make an appeal.

Balance Billing: When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As an enrollee of UHC Dual Choice DC-S001 (PPO D-SNP), you only have to pay our plan's allowed cost-sharing amounts when you get services covered by our plan. We do not allow network providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay. In some cases, out-of-network providers can balance bill you for covered services. If you obtain covered services from an out-of-network provider who does not accept Medicare assignment, you will be responsible for the plan cost-sharing, plus any difference between the amount we pay the provider and the Medicare limiting charge.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Benefit period: The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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.

Biosimilar: A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized Care Plan."

Care team: Refer to "Interdisciplinary Care Team."

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of your **Enrollee Handbook** explains how to contact CMS.

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.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".

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. As a enrollee, you do not have coinsurance, but you must continue to pay your Medicare premiums if you have Medicare.

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

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

Cost-sharing: Amounts you have to pay when you get certain services or prescription drugs. Cost-sharing includes copays.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your **Enrollee Handbook** explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

DC Medicaid: This is the name of the District of Columbia's (the District's) Medicaid program. DC Medicaid is run by the District and is paid for by the District and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary by jurisdiction, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Deductible: The amount you must pay for health care or prescriptions before our plan pays. As an enrollee, you have no deductibles.

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

Dispensing Fee: A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Drug management program (DMP): A program that helps make sure enrollees safely use prescription opioids and other frequently abused medications.

Dual eligible individual: A person who qualifies for Medicare and DC Medicaid coverage.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you are a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Enrollee (enrollee of our plan, or "plan enrollee"): 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).

Enrollee Handbook and Disclosure Information: This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as an enrollee of our plan.

Enrollee Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your **Enrollee Handbook** for more information about Enrollee Services.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations. You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Excluded Services: Services that are not covered by this health plan.

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

Generic drug: A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan. This does not involve coverage or payment disputes.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long- term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

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 Medical Benefits Chart in **Chapter 4, Section D** 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 and/or DC Medicaid 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 usually include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

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

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**.

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."

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Enrollee Services if you get any bills you don't understand.

Because we pay the entire cost for your services, you do not owe any cost-sharing. Providers should not bill you anything for these services.

? **If you have questions,** please call UHC Dual Choice DC-S001 (PPO D-SNP) at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September. The call is free.
For more information, visit **myuhc.com/CommunityPlan**.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. 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. The formal name is the **Independent Review Entity**.

Individualized Care Plan (ICP or Care Plan): A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

List of Covered Drugs ("Drug List"): A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The "Drug List" tells you if there are any rules you need to follow to get your drugs. The "Drug List" is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF). LTSS is available to enrollees who meet certain clinical and financial requirements. For more information on LTSS, call Enrollee Services at **1-866-242-7726**.

Low-income subsidy (LIS): Refer to "Extra Help"

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

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

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can

get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage: A Medicare program, also known as "Medicare Part C" or "MA", that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits. A Medicare Advantage Plan can be 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 Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare Coverage Gap Discount Program: A program that provides discounts on most covered Part D brand name drugs to Part D enrollees 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. For this reason, most, but not all, brand name drugs are discounted.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part 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 diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a "dually eligible individual".

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as "Medicare Advantage" or "MA", that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare prescription drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A distinct service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your **Enrollee Handbook** for more information.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan enrollees. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

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

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and do not charge enrollees an extra amount.
- While you're an enrollees of our plan, you must use network providers to get covered services. Network providers are also called "plan providers".

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of your **Enrollee Handbook**.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of your **Enrollee Handbook** explains coverage decisions.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).

- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to enrollees of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or **Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to enrollees of our plan. **Chapter 3** of your **Enrollee Handbook** explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

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

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

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your **Enrollee Handbook** for information about getting care from primary care providers.

Preferred Provider Organization (PPO) Plan: A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan enrollees for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Enrollee cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from in-network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium: The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription drug benefit manager: Third party prescription drug organization responsible for processing and paying prescription drug claims, developing, and maintaining the formulary, and negotiating discounts and rebates with drug manufacturers.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your **Enrollee Handbook** for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of your **Enrollee Handbook**. Our plan covers some drugs only if you get PA from us.
- Covered drugs that need our plan's PA are marked in the **List of Covered Drugs**.

Program for All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home. 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 Enrollee Services at **1-866-242-7726**.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

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

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your **Enrollee Handbook** for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs 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 drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of your **Enrollee Handbook**.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your **Enrollee Handbook** to learn more about rehabilitation services.

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 Medical Benefit Chart in **Chapter 4**.)

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

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Special Needs Plan: A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

UHC Dual Choice DC-S001 (PPO D-SNP) Enrollee Services:

Call **1-866-242-7726**
Calls to this number are free.
8:00 a.m.–8:00 p.m., 7 days a week, October–March;
8:00 a.m.–5:30 p.m., Monday–Friday, April–September
Enrollee Services also has free language interpreter services available for non-English speakers.

711
Calls to this number are free.
8:00 a.m.–8:00 p.m., 7 days a week, October–March;
8:00 a.m.–5:30 p.m., Monday–Friday, April–September

Write: **UHC Community Plan**
P.O. Box 30769
Salt Lake City, UT 84130-0769

myuhc.com/CommunityPlan