

Evidence of Coverage 2025

UHC Nursing Home Plan EX-F003 (PPO I-SNP)



MyUHCMedicare.com



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

United Healthcare

January 1 – December 31, 2025

Evidence of Coverage

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

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2025.



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

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

This plan, UHC Nursing Home Plan EX-F003 (PPO I-SNP), is insured through UnitedHealthcare Insurance Company or one of its affiliates. (When this **Evidence of Coverage** says "we," "us," or "our," it means UnitedHealthcare. When it says "plan" or "our plan," it means UHC Nursing Home Plan EX-F003 (PPO I-SNP).)

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

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

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

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2026. The formulary, pharmacy network, and provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

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

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

2025 Evidence of Coverage Table of Contents

Chapter 1:	Getting star	ted as a member	1
	Section 1	Introduction	2
	Section 2	What makes you eligible to be a plan member?	3
	Section 3	Important membership materials you will receive	4
	Section 4	Your monthly costs for the plan	6
	Section 5	More information about your monthly premium	9
	Section 6	Keeping your plan membership record up to date	10
	Section 7	How other insurance works with our plan	. 11
Chapter 2:	Important p	hone numbers and resources	.13
	Section 1	UHC Nursing Home Plan EX-F003 (PPO I-SNP) Contacts (how to contact us, including how to reach Customer Service)	.14
	Section 2	Medicare (how to get help and information directly from the federal Medicare program)	.18
	Section 3	State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)	.20
	Section 4	Quality Improvement Organization	21
	Section 5	Social Security	. 22
	Section 6	Medicaid	.23
	Section 7	Information about programs to help people pay for their prescription drugs	
	Section 8	How to contact the Railroad Retirement Board	.27
	Section 9	Do you have "group insurance" or other health insurance from an employer?	.28
Chapter 3:	Using the pl	an for your medical services	29
	Section 1	Things to know about getting your medical care as a member of our plan	
	Section 2	Using network and out-of-network providers to get your medical care	
	Section 3	How to get services when you have an emergency or urgent need for care or during a disaster	
	Section 4	What if you are billed directly for the full cost of your services?	36

	Section 5	How are your medical services covered when you are in a "clinical research study"?	
	Section 6	Rules for getting care in a "religious non-medical health care institution"	38
	Section 7	Rules for ownership of durable medical equipment	39
Chapter 4:	Medical Be	nefits Chart (what is covered and what you pay)	41
	Section 1	Understanding your out-of-pocket costs for covered services	42
	Section 2	Use the medical benefits chart to find out what is covered and how much you will pay	
	Section 3	What services are not covered by the plan?	
Chapter 5:	Using the p	lan's coverage for Part D prescription drugs	. 128
	Section 1	Introduction	129
	Section 2	Fill your prescription at a network pharmacy or through the plan's order service	
	Section 3	Your drugs need to be on the plan's Drug List	132
	Section 4	There are restrictions on coverage for some drugs	
	Section 5	What if one of your drugs is not covered in the way you'd like it to covered?	
	Section 6	What if your coverage changes for one of your drugs?	137
	Section 7	What types of drugs are not covered by the plan?	
	Section 8	Filling a prescription	
	Section 9	Part D drug coverage in special situations	140
	Section 10	Programs on drug safety and managing medications	
Chapter 6:	What you p	ay for your Part D prescription drugs	. 144
	Section 1	Introduction	
	Section 2	What you pay for a drug depends on which "drug payment stage" are in when you get the drug	
	Section 3	We send you reports that explain payments for your drugs and wh payment stage you are in	
	Section 4	During the Deductible Stage, you pay the full cost of your drugs	149
	Section 5	During the Initial Coverage Stage, the plan pays its share of your doosts and you pay your share	_
	Section 6	During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs	

	Section 7	Additional benefits information	. 151
	Section 8	Part D Vaccines. What you pay for depends on how and where you them	_
Chapter 7:	Asking us to	pay our share of a bill you have received for covered medical	
	services or	drugs	.154
	Section 1	Situations in which you should ask us to pay our share of the cost your covered services or drugs	
	Section 2	How to ask us to pay you back or to pay a bill you have received	157
	Section 3	We will consider your request for payment and say yes or no	. 158
Chapter 8:	Your rights	and responsibilities	159
	Section 1	Our plan must honor your rights and cultural sensitivities as a mem of the plan	
	Section 2	You have some responsibilities as a member of the plan	. 172
Chapter 9:	What to do	if you have a problem or complaint (coverage decisions, appeals	,
	complaints		.174
	Section 1	Introduction	175
	Section 2	Where to get more information and personalized assistance	. 175
	Section 3	To deal with your problem, which process should you use?	. 176
	Section 4	A guide to the basics of coverage decisions and appeals	. 176
	Section 5	Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision	
	Section 6	Your Part D prescription drugs: How to ask for a coverage decision make an appeal	
	Section 7	How to ask us to cover a longer inpatient hospital stay if you think are being discharged too soon	•
	Section 8	How to ask us to keep covering certain medical services if you thin your coverage is ending too soon	
	Section 9	Taking your appeal to Level 3 and beyond	. 203
	Section 10	How to make a complaint about quality of care, waiting times, customer service, or other concerns	. 206
Chapter 10:	Ending you	r membership in the plan	210
	Section 1	Introduction to ending your membership in our plan	211
	Section 2	When can you end your membership in our plan?	. 211

	Section 3	How do you end your membership in our plan?	212
	Section 4	Until your membership ends, you must keep getting your medical items, services and drugs through our plan	
	Section 5	We must end your membership in the plan in certain situations	
Chapter 11:	Legal notice	es	215
	Section 1	Notice about governing law	216
	Section 2	Notice about non-discrimination	216
	Section 3	Notice about Medicare Secondary Payer subrogation rights	216
	Section 4	Third party liability and subrogation	216
	Section 5	Member liability	217
	Section 6	Medicare-covered services must meet requirement of reasonable necessary	
	Section 7	Non duplication of benefits with automobile, accident or liability coverage	
	Section 8	Acts beyond our control	
	Section 9	Contracting medical providers and network hospitals are indepen contractors	
	Section 10	Technology assessment	219
	Section 11	Member statements	219
	Section 12	Information upon request	219
	Section 13	2025 Enrollee Fraud & Abuse Communication	219
	Section 14	Commitment of Coverage Decisions	220
Chapter 12:	Definitions	of important words	221

Chapter 1

Getting started as a member

Section 1 Introduction Section 1.1 You are currently enrolled in UHC Nursing Home Plan EX-F003 (PPO I-SNP), which is a specialized Medicare Advantage Plan ("Special Needs Plan")

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, UHC Nursing Home Plan EX-F003 (PPO I-SNP).

UHC Nursing Home Plan EX-F003 (PPO I-SNP) is a specialized Medicare Advantage Plan (a Medicare Advantage "Special Needs Plan"), which means its benefits are designed for people with special health care needs. UHC Nursing Home Plan EX-F003 (PPO I-SNP) is designed for people who live in an institution (like a nursing home) and/or live in the community but who need a level of care that is usually provided in a nursing home.

Our plan includes providers who specialize in treating patients who need this level of care. As a member of the plan, you get specially tailored benefits and have all your care coordinated through our plan.

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

Section 1.2 What is the Evidence of Coverage document about?

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

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

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

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

Section 1.3 Legal information about the Evidence of Coverage

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

The contract is in effect for months in which you are enrolled in the plan between January 1, 2025 and December 31, 2025.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of the plan after December 31, 2025. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2025.

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

Section 2.1 Your eligibility requirements You are eligible for membership in our plan as long as: You have both Medicare Part A and Medicare Part B — and — you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it. — and — you are a United States citizen or are lawfully present in the United States

Special eligibility requirements for our plan

Our plan is designed to meet the specialized needs of people who need a level of care that is usually provided in a nursing home.

□ **– and –** you meet the special eligibility requirements described below.

To be eligible for our plan, you must live in a nursing home available through our plan. Please see the plan's **Provider Directory** for a list of our contracted nursing homes or call Customer Service and ask us to send you a list.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within 6 month(s), then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

Section 2.2 Here is the plan service area for UHC Nursing Home Plan EX-F003 (PPO I-SNP)

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

Our service area includes the state of Connecticut and these counties in

Maine: Cumberland, Franklin, Kennebec, Oxford, Penobscot, Somerset, York;

New Hampshire: Belknap, Carroll, Cheshire, Coos, Grafton, Hillsborough, Merrimack, Rockingham, Strafford, Sullivan;

New Jersey: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Union.

We offer coverage in several states. However, there may be cost or other differences between the plans we offer in each state. If you move out of state and into a state that is still within our service area, you must call Customer Service in order to update your information.

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

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

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

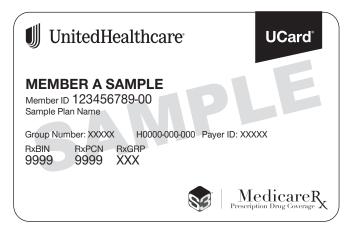
Section 2.3 U.S. Citizen or Lawful Presence

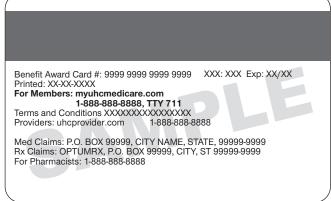
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify UHC Nursing Home Plan EX-F003 (PPO I-SNP) if you are not eligible to remain a member on this basis. UHC Nursing Home Plan EX-F003 (PPO I-SNP) must disenroll you if you do not meet this requirement.

Section 3 Important membership materials you will receive

Section 3.1 Your UnitedHealthcare UCard

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





Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your UnitedHealthcare UCard, you

may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

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

Section 3.2 Provider Directory

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

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (Using the plan's coverage for your medical services) for more specific information.

The most recent list of providers and suppliers is available on our website at MyUHCMedicare.com. If you don't have your copy of the **Provider Directory**, you can request a copy (electronically or in hardcopy form) from Customer Service. Requests for hard copy Provider Directories will be mailed to you within three business days.

Section 3.3 Pharmacy Directory

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

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

Section 3.4 The plan's List of Covered Drugs (Formulary)

The plan has a **List of Covered Drugs (Formulary)**. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

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

To get the most complete and current information about which drugs are covered, you can visit the plan's website (MyUHCMedicare.com) or call Customer Service.

Section 4 Your monthly costs for the plan

Your costs may include the following:	
□Plan Premium (Section 4.1)	
☐Monthly Medicare Part B Premium (Section 4.2)	
☐Part D Late Enrollment Penalty (Section 4.3)	
☐Income Related Monthly Adjusted Amount (Section 4.4)	
☐ Medicare Prescription Payment Plan Amount (Section 4.5)	

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are **already enrolled** and getting help from one of these programs, **the information about premiums in this Evidence of Coverage may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the cover of this booklet.)

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions, about these premiums review your copy of Medicare & You 2025 handbook, the section called "2025 Medicare Costs." If you need a copy, you can download it from the Medicare website (medicare.gov/medicare-and-you). Or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. For 2025, the monthly premium for our plan is \$53.10.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

As a member of UHC Nursing Home Plan EX-F003 (PPO I-SNP) you receive up to a \$0.20 reduction of your monthly Medicare Part B premium. The reduction is set up by Medicare and administered through the Social Security Administration (SSA). Rebates apply only to amounts you pay toward the Medicare Part B premium and are not issued on any premium amount paid by Medicaid. Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement. Reductions may take several months to be issued; however, you will receive a full credit for amounts you have paid.

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

Section 4.3 Part D Late Enrollment Penalty

You will not have to pay it if:

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

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in our plan, we let you know the amount of the penalty.

. eaetetetetetetetetetetetetetetetetet
□You receive "Extra Help" from Medicare to pay for your prescription drugs.
□You have gone less than 63 days in a row without creditable coverage.
□You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Veterans Health Administration (VA). 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 2025, this average premium amount is \$36.78.
□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 \$36.78, which equals \$5.15. This rounds to \$5.20. 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 <u>under</u> 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

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

Section 4.4 Income Related Monthly Adjustment Amount

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

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.

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

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your Medicare-

covered Part D prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any Part D prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

Section 5 More information about your monthly premium

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

There are four ways you can pay your plan premium.

Option 1: Paying by check

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

Option 2: Electronic Funds Transfer

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

Option 3: Paying by credit card

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

Option 4: Having your plan premium taken out of your monthly Social Security check Changing the way you pay your premium

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

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

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

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

If we end your membership because you did not pay your plan premium, you will have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

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

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 9 for how to file a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your plan premium within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint or you can call us at 1-800-711-0646 between 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept. TTY users should call 711. You must make your request no later than 60 calendar days after the date your membership ends.

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

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

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay all or part of the member's monthly plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

Section 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

	□Changes to your name, your address, or your phone number.
	□ Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid).
	☐ If you have any liability claims, such as claims from an automobile accident.
	☐ If you have been admitted to a nursing home.
	☐ If you receive care in an out-of-area or out-of-network hospital or emergency room.
	☐ If your designated responsible party (such as a caregiver) changes.
	□ If you are participating in a clinical research study. (Note: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so.)
li	f any of this information changes, please let us know by calling Customer Service.
	t is also important to contact Social Security if you move or change your mailing address. You can

Section 7 How other insurance works with our plan

Other insurance

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

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

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

_												
Т	hese	rules	annly	tor 6	amnlı	OVE	\circ r	union	aroun	health	nlan	coverage:

□ If you have retiree coverage, Medicare pays first.

□ If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
☐ If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
☐ If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.
These types of coverage usually pay first for services related to each type:
□No-fault insurance (including automobile insurance)
□Liability (including automobile insurance)
□Black lung benefits
□Workers' Compensation
Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

Chapter 2

Important phone numbers and resources

Section 1 UHC Nursing Home Plan EX-F003 (PPO I-SNP) Contacts (how to contact us, including how to reach Customer Service)

How to contact our plan's Customer Service

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

Method	Customer Service - Contact Information
Call	1-800-711-0646 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Write	UnitedHealthcare Customer Service Department P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	MyUHCMedicare.com

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

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

Method	Coverage Decisions for Medical Care - Contact Information
Call	1-800-711-0646 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	711
	Calls to this number are free.

Method	Coverage Decisions for Medical Care - Contact Information
	Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	1-888-950-1170
Write	UnitedHealthcare Customer Service Department (Organization Determinations) P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	MyUHCMedicare.com

Method	Appeals for Medical Care - Contact Information
Call	1-800-711-0646 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept For fast/expedited appeals for medical care: 1-877-262-9203 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	711
	Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	For fast/expedited appeals only: 1-866-373-1081
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6106, MS CA120-0360, Cypress, CA 90630-0016
Website	MyUHCMedicare.com

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
Call	1-800-711-0646 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	711

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
	Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Write	Optum Rx Prior Authorization Department P.O. Box 25183, Santa Ana, CA 92799
Website	MyUHCMedicare.com

Method	Appeals for Part D Prescription Drugs - Contact Information
Call	1-800-711-0646 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept For fast/expedited appeals for Part D prescription drugs: 1-800-595-9532 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	711
	Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	For standard Part D prescription drug appeals: 1-866-308-6294 For fast/expedited Part D prescription drug appeals: 1-866-308-6296
Write	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA120-0368, Cypress, CA 90630-0016
Website	MyUHCMedicare.com

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

You can make a complaint about us or one of our network providers, or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

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

Method	Complaints about Medical Care - Contact Information
	Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept For fast/expedited complaints about medical care: 1-877-262-9203 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	For fast/expedited complaints only: 1-866-373-1081
Write	UnitedHealthcare Appeals and Grievances Department P.O. Box 6106, MS CA120-0360, Cypress, CA 90630-0016
Medicare Website	You can submit a complaint about UHC Nursing Home Plan EX-F003 (PPO I-SNP) directly to Medicare. To submit an online complaint to Medicare, go to medicare.gov/MedicareComplaintForm/home.aspx.

Method	Complaints about Part D Prescription Drugs – Contact Information
Call	1-800-711-0646 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept For fast/expedited complaints about Part D prescription drugs: 1-800-595-9532 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Fax	For standard Part D prescription drug complaints: 1-866-308-6294 For fast/expedited Part D prescription drug complaints: 1-866-308-6296
Write	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6106, MS CA120-0368, Cypress, CA 90630-0016

Method	Complaints about Part D Prescription Drugs - Contact Information
Medicare Website	You can submit a complaint about UHC Nursing Home Plan EX-F003 (PPO I-SNP) directly to Medicare. To submit an online complaint to Medicare, go to medicare.gov/MedicareComplaintForm/home.aspx.

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (Asking us to pay our share of a bill you have received for covered medical services or drugs).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for more information.

Method	Payment Requests - Contact Information
Call	1-800-711-0646 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Write	Medical claims payment requests: UnitedHealthcare P.O. Box 31362, Salt Lake City, UT 84131-0362 Part D prescription drug payment requests: Optum Rx P.O. Box 650287, Dallas, TX 75265-0287
Website	MyUHCMedicare.com

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

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

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

Method	Medicare - Contact Information
Call	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Website	medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: Medicare Eligibility Tool: Provides Medicare eligibility status information. 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 Nursing Home Plan EX-F003 (PPO I-SNP): Tell Medicare about your complaint: You can submit a complaint about UHC Nursing Home Plan EX-F003 (PPO I-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 its computer. Or, you can call Medicare and tell them what information you are looking for. They will find

Method	Medicare - Contact Information
	can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- Connecticut Connecticut CHOICES Senior Health Insurance Program
- Maine Maine State Health Insurance Assistance Program (SHIP)
- New Hampshire New Hampshire SHIP ServiceLink Aging and Disability Resource Center
- New Jersey New Jersey State Health Insurance Assistance Program (SHIP)

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

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

Method to access SHIP and other resources

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

State Health Insurance Assistance Programs (SHIP) - Contact Information

Connecticut | Connecticut CHOICES Senior Health Insurance Program

55 Farmington AVE, FL 12 Hartford, CT 06105-3730 https://portal.ct.gov/AgingandDisability/Content-Pages/Programs/CHOICES-Connecticuts-program-for-Health-insurance-assistance-Outreach-Information-and-referral-Couns

1-800-994-9422 TTY 711

State Health Insurance Assistance Programs (SHIP) - Contact Information	
Maine Maine State Health Insurance Assistance Program (SHIP) 109 Capitol Street Augusta, ME 04333 https://www.maine.gov/dhhs/programs-services/health-insurance	1-207-287-3707 TTY 711
New Hampshire New Hampshire SHIP - ServiceLink Aging and Disability Resource Center 25 Roxbury St, STE 106 Keene, NH 03431 https://www.servicelink.nh.gov	1-866-634-9412 TTY 1-800-735-2964
New Jersey New Jersey State Health Insurance Assistance Program (SHIP) P.O. Box 715 Trenton, NJ 08625-0715 www.nj.gov/humanservices/doas/services/q-z/ship/index.shtml	1-800-792-8820 TTY 711

Section 4 Quality Improvement Organization

There is a designated Quality Improvement Organization serving Medicare beneficiaries in each state. Here is a list of the Quality Improvement Organizations in each state we serve:

- Connecticut ACENTRA
- Maine ACENTRA
- New Hampshire ACENTRA
- New Jersey Livanta BFCC-QIO Program

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

ou should contact your state's Quality Improvement Organization in any of these situations:
☐You have a complaint about the quality of care you have received.
☐You think coverage for your hospital stay is ending too soon.
□You think coverage for your home health care, skilled nursing facility care, or Comprehensive
Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Quality Improvement Organization (QIO) - Contact Information	n
Connecticut ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-319-8452 TTY 711 9 a.m 5 p.m. local time, Monday - Friday; 10 a.m. 4 p.m. local time, weekends and holidays
Maine ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-319-8452 TTY 711 9 a.m 5 p.m. local time, Monday - Friday; 10 a.m. 4 p.m. local time, weekends and holidays
New Hampshire ACENTRA 5201 W Kennedy BLVD, STE 900 Tampa, FL 33609 acentraqio.com	1-888-319-8452 TTY 711 9 a.m 5 p.m. local time, Monday - Friday; 10 a.m. 4 p.m. local time, weekends and holidays
New Jersey Livanta BFCC-QIO Program 10820 Guilford RD, STE 202 Annapolis Junction, MD 20701 www.livantaqio.com	1-866-815-5440 TTY 711 9 a.m 5 p.m. local time, Monday - Friday; 10 a.m. 4 p.m. local time, weekends and holidays

Section 5 Social Security

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

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

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

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

Section 6 Medicaid

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

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

- □ Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

 □ Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

 □ Qualifying Individual (QI): Helps pay Part B premiums.
- □ Qualified Disabled & Working Individuals (QDWI): Helps pay Part A premiums.

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

State Medicaid Programs - Contact Information	
Connecticut Connecticut State Medicaid 55 Farmington AVE Hartford, CT 06105-3730 portal.ct.gov/husky	1-877-284-8759 TTY 1-866-492-5276 8:30 a.m 6:00 p.m. local time, Monday - Friday
Maine Office of MaineCare Services 11 State House Station Augusta, ME 04333-0011 https://www.maine.gov/dhhs/oms/	1-800-977-6740 TTY 711 8:30 a.m 6:00 p.m. local time, Monday - Friday
New Hampshire New Hampshire Department of Health and Human Services 129 Pleasant ST Concord, NH 03301-3852 https://www.dhhs.nh.gov/ombp/medicaid/	1-844-275-3447 TTY 1-800-735-2964 8:30 a.m 6:00 p.m. local time, Monday - Friday
New Jersey Department of Human Services Division of Medical Assistance & Health Services P.O. Box 712 Trenton, NJ 08625-0712 https://www.state.nj.us/humanservices/dmahs/	1-800-701-0710 TTY 711 8:30 a.m 6:00 p.m. local time, Monday - Friday

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

The Medicare.gov website (medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

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

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

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

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

□ Fax the information to 501-262-7070 or mail it to P.O. Box 29300, Hot Springs, AR 71903-9300. □ When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we

may make the payment directly to the pharmacy. If a state paid on your behalf, we may make

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

payment directly to the state. Please contact Customer Service if you have questions.

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

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

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

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

AIDS Drug Assistance Program (ADAP) - Contact Information	
Connecticut Connecticut ADAP Magellan Health Services P.O. Box 9971 Glen Allen, VA 23060 https://ctdph.magellanrx.com	1-800-424-3310 8 a.m4 p.m. local time, Monday-Friday
Maine Maine AIDS Drug Assistance Program 11 State House Station, 286 Water ST Augusta, ME 04330 http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/ services/aids-drug-assist.shtml	1-207-287-3747 8 a.m5 p.m. local time, Monday-Friday

AIDS Drug Assistance Program (ADAP) – Contact Information New Hampshire New Hampshire ADAP 129 Pleasant ST Concord, NH 03301 https://www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-adap 1-603-271-4496 8 a.m4:30 p.m. local time, Monday-Friday	

State Pharmaceutical Assistance Programs

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

Here is a list of the State Pharmaceutical Assistance Programs in each state we serve:

- Connecticut Connecticut AIDS Drug Assistance Program (CADAP)
- Maine Office of MaineCare Services
- New Jersey New Jersey Pharmaceutical Assistance To The Aged & Disabled (PAAD)

State Pharmaceutical Assistance Programs - Contact Information	
Connecticut Connecticut AIDS Drug Assistance Program (CADAP) c/o Magellan Health, 15 Cornell RD, STE 2201 Lathan, NY 12110 https://ctdph.magellanrx.com/	1-800-424-3310 TTY 711 8 a.m 4 p.m. local time, Monday - Friday
Maine Office of MaineCare Services 109 Capitol ST 11 State House Station Augusta, ME 04333-0011 https://www.maine.gov/dhhs/oms	1-800-977-6740 TTY 711 7 a.m 6 p.m. local time, Monday - Friday
New Jersey New Jersey Pharmaceutical Assistance To The Aged & Disabled (PAAD) P.O. Box 715 Trenton, NJ 08625-0715 http://www.state.nj.us/humanservices/doas/paad/	1-800-792-9745 TTY 711 8:30 a.m 4:30 p.m. loca time, Monday - Friday

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December). This payment option might help you

manage your expenses, but it doesn't save you money or lower your drug costs. "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. Contact us or visit Medicare.gov to find out if this payment option is right for you.

Method	The Medicare Prescription Payment Plan - Contact Information
Call	1-800-711-0646 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours of Operation: 8 a.m8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept
Write	UnitedHealthcare Customer Service Department P.O. Box 30770, Salt Lake City, UT 84130-0770
Website	MyUHCMedicare.com

Section 8 How to contact the Railroad Retirement Board

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

Method	Railroad Retirement Board - Contact Information
Call	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701

Method	Railroad Retirement Board - Contact Information
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are not free.
Website	rrb.gov/

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

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

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

Chapter 3

Using the plan for your medical services

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

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

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

	, , ,
Section 1.1	What are "network providers" and "covered services"?
	are doctors and other health care professionals licensed by the state to provide ces and care. The term "providers" also includes hospitals and other health care
hospitals, and and your cos deliver covere	oviders" are the doctors and other health care professionals, medical groups, dother health care facilities that have an agreement with us to accept our payment tesharing amount as payment in full. We have arranged for these providers to ed services to members in our plan. The providers in our network bill us directly for e you. When you see a network provider, you pay only your share of the cost for .
and prescript	rvices" include all the medical care, health care services, supplies, equipment, ion drugs that are covered by our plan. Your covered services for medical care are enefits chart in Chapter 4. Your covered services for prescription drugs are Chapter 5.
Section 1.2	Basic rules for getting your medical care covered by the plan
	ealth plan, UHC Nursing Home Plan EX-F003 (PPO I-SNP) must cover all services nal Medicare and must follow Original Medicare's coverage rules.
The plan will gen	erally cover your medical care as long as:
_	receive is included in the plan's Medical Benefits Chart (this chart is in this document).
☐The care you	receive is considered medically necessary. "Medically necessary" means that

the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

You receive your care from a provider who is eligible to provide services under Original Medicare. As a member of our plan, you can receive your care from either a network provider

☐ The providers in our network are listed in the **Provider Directory (MyUHCMedicare.com).**

or an out-of-network provider (for more about this, see Section 2 in this chapter).

- ☐ If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who has opted out of or been excluded or precluded from the Medicare Program. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

Section 2 Using network and out-of-network providers to get your medical care Section 2.1 You may choose a primary care provider (PCP) to provide and oversee your medical care

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

What is a PCP?

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

What types of providers may act as a PCP?

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

What is the role of my PCP?

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

How do you choose your PCP?

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

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

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

Changing your PCP

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

If you want to change your PCP, call Customer Service or go online. If the PCP is accepting additional plan members, the change will become effective on the first day of the following month.

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

A specialist is a doctor who provides health care services for a specific disease or part of the bo There are many kinds of specialists. Here are a few examples:	ody.
□Oncologists care for patients with cancer.	
□Cardiologists care for patients with heart conditions.	
□Orthopedists care for patients with certain bone, joint, or muscle conditions.	
If you use an out-of-network provider, your share of the costs for your covered services will be a shown in the Benefits Chart in Chapter 4 under "Out-of-Network." You pay the out-of-network costaining even if you received a referral for the services, or if you requested a pre-visit coverage	
decision from us. However, in the event that no contracted network provider is available, you ca ask to access care at in-network cost-sharing from an out-of-network provider. Call Customer	เท

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

Service to let us know if you need to see an out-of-network provider, or to get help finding an innetwork provider. (Phone numbers for Customer Service are printed on the cover of this booklet.)

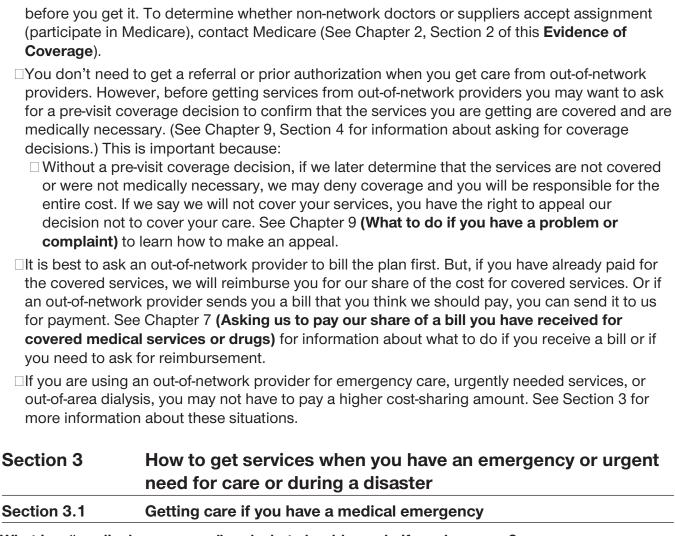
Please refer to the **Provider Directory** for a listing of plan specialists available through your network, or you may consult the **Provider Directory** online at the website listed in Chapter 2 of this booklet.

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

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

an you have certain rights and protections that are summarized below:
□ Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
□We will notify you that your provider is leaving our plan so that you have time to select a new provider.
 If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.

	ur other providers leave our plan, we will notify you if you are assigned to the urrently receive care from them, or have seen them within the past three months.
□We will assist continued car	you in selecting a new qualified in-network provider that you may access for e.
have the right	ently undergoing medical treatment or therapies with your current provider, you to request, and we will work with you to ensure, that the medically necessary herapies you are receiving continues.
•	e you with information about the different enrollment periods available to you and any have for changing plans.
but at in-netwo	e for any medically necessary covered benefit outside of our provider network, ork cost sharing, when an in-network provider or benefit is unavailable or meet your medical needs.
•	your doctor or specialist is leaving your plan, please contact us so we can assist a new provider to manage your care.
provider or the	we have not furnished you with a qualified provider to replace your previous at your care is not being appropriately managed, you have the right to file a quality aint to the QIO, a quality of care grievance to the plan, or both. Please see
You may call Cus	tomer Service for assistance at the number listed in Chapter 2 of this booklet.
authorization is th	quire prior authorization from the plan in order to be covered. Obtaining prior e responsibility of the PCP or treating provider. Services and items requiring prior listed in Medical Benefits Chart in Chapter 4, Section 2.1.
Section 2.3	How to get care from out-of-network providers
please note proviemergency situat as long as the ser out-of-network p	our plan, you can choose to receive care from out-of-network providers. However, ders that do not contract with us are under no obligation to treat you, except in ions. Our plan will cover services from either network or out-of-network providers, vices are covered benefits and are medically necessary. However, if you use an rovider, your share of the costs for your covered services may be higher. portant things to know about using out-of-network providers:
must be eligib provider who you receive ca responsible fo	our care from an out-of-network provider, however, in most cases that provider ble to participate in Medicare. Except for emergency care, we cannot pay a has opted out of or been excluded or precluded from the Medicare Program. If are from a provider who is not eligible to participate in Medicare, you will be or the full cost of the services you receive. Check with your provider before ices to confirm that they are eligible to participate in Medicare.
Medicare rule assignment. A with Medicare	ain services out-of-network, we will pay for covered services using Original s. Under Original Medicare, providers can choose whether to accept Medicare assignment means that the doctor, provider, or supplier has signed an agreement to accept the Medicare-approved amount as full payment for covered services. providers, and suppliers accept assignment, but you should always check to



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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost-sharing.

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was **not** an emergency, the amount of cost-sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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

What are "urgently needed services"?

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

Our plan covers neither emergency services, urgently needed services, nor any other services if you receive care outside of the United States.

Section 3.3 Getting care during a disaster

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

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

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

disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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

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

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

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

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

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

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

Section 5.1 What is a "clinical research study"?

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

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for in-network cost-sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost-sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research

study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

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

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

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

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine)
items and services you receive as part of the study, including:	
\square Room and board for a hospital stay that Medicare would pay for even if you weren't in a stud	y.
\square An operation or other medical procedure if it is part of the research study.	
☐ Treatment of side effects and complications of the new care.	

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

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

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

\square Generally, Medicare will not pay for the new item or service that the study is testing unles
Medicare would cover the item or service even if you were not in a study.

□ltems or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.
□ltems and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial.

Do you want to know more?

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

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

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

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

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

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

and not required by any federal, state, or local law.
\square "Excepted" medical treatment is medical care or treatment that you get that is not voluntary or
is required under federal, state, or local law.

T on m

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

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

Medicare Inpatient Hospital coverage limits apply. The coverage limits are described under **inpatient hospital care** in the medical benefits chart in Chapter 4.

Section 7 Rules for ownership of durable medical equipment Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

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

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

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

11	you qualify for Medicare oxygen equipment coverage our plan will cover:
	□Rental of oxygen equipment
	□Delivery of oxygen and oxygen contents
	$\hfill\square \mbox{Tubing}$ and related oxygen accessories for the delivery of oxygen and oxygen contents
	☐ Maintenance and repairs of oxygen equipment

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

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

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

Chapter 4

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

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

This chapter provides a medical benefits chart that lists your covered services and shows how much you will pay for each covered service as a member of UHC Nursing Home Plan EX-F003 (PPO I-SNP). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

□A "copayment	i" is the fixed	amount you pa	y each time y	ou recei	ve certai	n medic	cal se	rvices.
You pay a copa	ayment at the	e time you get th	ne medical se	rvice. (T	he medic	cal bene	efits c	hart in
Section 2 tells	you more ab	out your copayr	ments.)					
		_						

□ "Coinsurance" is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The medical benefits chart in Section 2 tells you more about your coinsurance.)

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

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

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

Your in-network maximum out-of-pocket amount is \$4,500. This is the most you pay during
the calendar year for covered Medicare Part A and Part B services received from network
providers. The amounts you pay for copayments and coinsurance for covered services from
network providers count toward this in-network maximum out-of-pocket amount. The amounts
you pay for plan premiums, Part D prescription drugs and services from out-of-network
providers do not count toward your in-network maximum out-of-pocket amount. In addition,
amounts you pay for some services do not count toward your in-network maximum out-of-
pocket amount. These services are marked with an asterisk in the medical benefits chart. If you
have paid \$4,500 for covered Part A and Part B services from network providers, you will not
have any out-of-pocket costs for the rest of the year when you see our network providers.
However, you must continue to pay your plan premium and the Medicare Part B premium
(unless your Part B premium is paid for you by Medicaid or another third party).

Your combined maximum out-of-pocket amount is \$6,700. This is the most you pay during
the calendar year for covered Medicare Part A and Part B services received from both in-
network and out-of-network providers. The amounts you pay for copayments and coinsurance
for covered services count toward this combined maximum out-of-pocket amount. The amounts

you pay for your plan premium and for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the medical benefits chart. If you have paid \$6,700 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

As a member of UHC Nursing Home Plan EX-F003 (PPO I-SNP), an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called "balance billing." This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

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

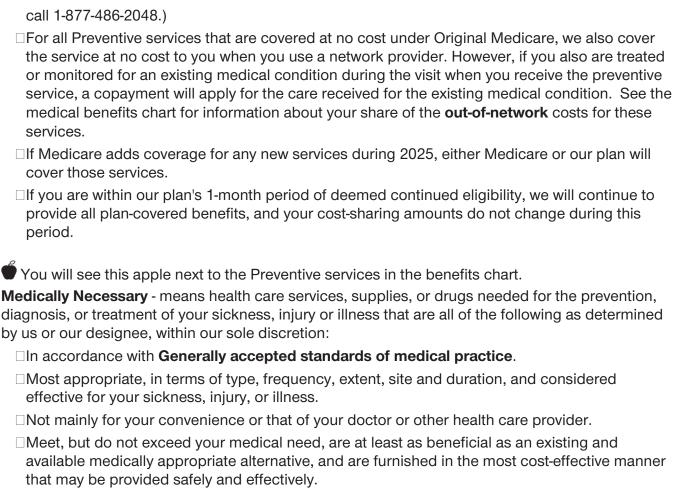
Section 2 Use the medical benefits chart to find out what is covered and how much you will pay

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

The medical benefits chart on the following pages lists the services UHC Nursing Home Plan EX-F003 (PPO I-SNP) covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is covered in Chapter 5. The services listed in the medical benefits chart are covered only when the following coverage requirements are met:

☐ Your Medicare-covered services	must be	provided	according	to the	coverage	guideline	S
established by Medicare.							

☐Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
□ For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
\square You have a Primary care provider (a PCP) who is providing and overseeing your care.
□Some of the services listed in the medical benefits chart are covered as in-network services only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from UHC Nursing Home Plan EX-F003 (PPO I-SNP).
Covered services that may need approval in advance to be covered as in-network services are marked by a double dagger (††) in the medical benefits chart.
 Network providers agree by contract to obtain prior authorization from the plan and agree not to balance bill you.
 You never need approval in advance for out-of-network services from out-of-network providers.
☐ While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
☐ If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.
Other important things to know about our coverage:
□ For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
□ Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less . (If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2025 handbook. View it online at medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should



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

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

Medical Benefits Chart

Services that are covered for you	What you must pay	What you must pay
	when you get these services In-Network	when you get these services Out-of-Network

Providers may ask you for more than one cost share payment if you get more than one service at an appointment. For example:

- Your doctor will ask for a copayment for the office or urgent care center visit and additional copayments for each x-ray that is performed while you are there.
- □Your hospital may ask for separate cost-sharing for certain outpatient hospital medical services for example but not limited to; radiological tests or Medicare Part B drugs administered while you are there.
- □Your pharmacist will ask for a separate copayment for each prescription he or she fills.
- The specific cost-sharing that will apply depends on which services you receive. The Medical benefits chart below lists the cost-sharing that applies for each specific service.

Abdominal aortic aneurysm screening

A one-time (once per lifetime) screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.

There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

30% coinsurance for members eligible for this preventive screening.
You pay these amounts

You pay these amounts until you reach the outof-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days performed by, or under the supervision of a physician (or other medical provider as described below) are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: Lasting 12 weeks or longer; nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); not associated with surgery; and not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Generally, Medicare-covered acupuncture services are not covered when provided by an acupuncturist or chiropractor. Provider Requirements:	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.††	You will pay the cost- sharing that applies to primary care services or specialist physician services (as described under "Physician/ practitioner services, including doctor's office visits") depending on if you receive services from a primary care physician or specialist.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:		
□ a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,		
□a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.		
Benefit is not covered when solely provided by an independent acupuncturist.		
Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS as required by Medicare.		
Acupuncture services performed by providers that do not meet CMS acupuncture provider requirements are		

plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that

transportation by ambulance is

medically required.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
not covered even in locations where there are no providers available that meet CMS requirements.		
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the	ground trip.	care-covered trips (in or the in-network out-of-obtain prior authorization

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
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.	\$0 copayment for a routine physical exam each year.	30% coinsurance for a routine physical exam each year.*
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. Note: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have	There is no coinsurance, copayment, or deductible for the annual wellness visit.	30% coinsurance for the annual wellness visit. You pay these amounts until you reach the outof-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.		
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.	30% coinsurance for Medicare-covered bone mass measurement. You pay these amounts until you reach the out-of-pocket maximum.
Breast cancer screening (mammograms) Covered services include: One baseline mammogram between the ages of 35 and 39 One screening mammogram every 12 months for women age 40 and older Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.	30% coinsurance for covered screening mammograms. You pay these amounts until you reach the outof-pocket maximum.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive	\$0 copayment for each Medicare-covered cardiac rehabilitative visit in a nursing home. †† 20% coinsurance for each Medicare-covered cardiac rehabilitative visit	30% coinsurance for each Medicare-covered cardiac rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	outside of a nursing home. ^{††} You pay these amounts until you reach the out-of-pocket maximum.	
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the cardiovascular disease preventive benefit.	30% coinsurance for the cardiovascular disease preventive benefit. You pay these amounts until you reach the outof-pocket maximum.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) covered once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.	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.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Cervical and vaginal cancer screening Covered services include: For all women: Pap tests and pelvic exams are covered once every 24 months If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months For asymptomatic women between the ages of 30 and 65: HPV testing once every 5 years, in conjunction with the Pap test	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	30% coinsurance for Medicare-covered preventive Pap and pelvic exams. You pay these amounts until you reach the out-of-pocket maximum.
Chiropractic services Covered services include: Manual manipulation of the spine to correct subluxation (when one or more of the bones of your spine move out of position). Manual manipulation is a treatment that uses hands-on pressure to gently move your joints and tissues. Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation, including: Maintenance therapy. Chiropractic treatment is considered maintenance therapy when	\$0 copayment for each Medicare-covered visit in a nursing home. †† 20% coinsurance for each Medicare-covered visit outside of a nursing home. †† You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each Medicare-covered visit. You pay these amounts until you reach the outof-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
continuous ongoing care is no longer expected to provide clinical improvements and the treatment becomes supportive instead of corrective.		
Extra charges when your chiropractor uses a manual, handheld device to add controlled pressure during treatment.		
□X-rays, massage therapy, and acupuncture (unless the acupuncture is for the treatment of chronic low back pain).		
Colorectal cancer screening The following screening tests are covered: Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes an outpatient diagnostic colonoscopy. There is no coinsurance, copayment, or deductible for each Medicare-covered barium enema.	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. 30% coinsurance for each Medicare-covered barium enema.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema.		You pay these amounts until you reach the out-of-pocket maximum.
Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.		
☐Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.		
□Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.		
Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.		
Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.		
Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Outpatient diagnostic colonoscopy	There is no coinsurance, copayment, or deductible for each Medicare-covered diagnostic colonoscopy.††	30% coinsurance for each Medicare-covered diagnostic colonoscopy. You pay these amounts until you reach the out-of-pocket maximum.
Routine dental benefits You can get more information about this benefit by viewing the Vendor Information Sheet at MyUHCMedicare.com or by calling Customer Service to have a paper copy sent to you.	You are covered for routine routine dental benefit desc chart for details.* ^{††}	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	30% coinsurance for an annual depression screening visit. You pay these amounts until you reach the out-of-pocket maximum.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.	30% coinsurance for the Medicare-covered diabetes screening tests. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
overweight and having a family history of diabetes. You may be eligible for up to two diabetes screenings every plan year following the date of your most recent diabetes screening test.		
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include:		
Supplies to monitor your blood glucose: continuous glucose monitors, blood glucose monitors, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	20% coinsurance for each Medicare-covered diabetes monitoring supply.†† You pay these amounts until you reach the out-of-pocket maximum. 20% 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. For cost-sharing applicable to insulin and	30% coinsurance for each Medicare-covered diabetes monitoring supply. You pay these amounts until you reach the out-of-pocket maximum. 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. For cost-sharing applicable to insulin and syringes, see Chapter 6 -

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	syringes, see Chapter 6 - What you pay for your Part D prescription drugs.	What you pay for your Part D prescription drugs.
For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	20% coinsurance for each pair of Medicare-covered therapeutic shoes. †† You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each pair of Medicare-covered therapeutic shoes. You pay these amounts until you reach the out-of-pocket maximum.
Diabetes self-management training is covered under certain conditions. Limited to 20 visits of 30 minutes per year for a maximum of 10 hours the initial year. Follow-up training subsequent years after, limited to 4 visits of 30 minutes for a maximum of 2 hours per year.	\$0 copayment for Medicare-covered benefits.	30% coinsurance for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.
Durable medical equipment (DME) and related supplies* (For a definition of "durable medical equipment," see Chapter 12 as well as Chapter 3, Section 7 of this document.)	20% coinsurance for Medicare-covered benefits. ^{††} Your cost-sharing for Medicare oxygen equipment coverage is	30% coinsurance for Medicare-covered benefits. Your cost sharing for Medicare oxygen equipment coverage is

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at MyUHCMedicare.com. If you're in a skilled nursing facility and the facility provides you with "durable medical equipment", the facility is responsible for this equipment.	20% coinsurance, every time you get covered equipment or supplies.†† Your cost-sharing will not change after being enrolled for 36 months. If prior to enrolling in our plan you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in our plan is 20% coinsurance.†† You pay these amounts until you reach the out-of-pocket maximum.	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 30% coinsurance. You pay these amounts until you reach the out-of-pocket maximum.
Emergency care	\$110 copayment for each	emeraency room visit.

Emergency care

Emergency care refers to services that are:

- □Furnished by a provider qualified to furnish emergency services, and
- Needed to evaluate or stabilize an emergency medical condition.

A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent \$110 copayment for each emergency room visit.

You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. If you are admitted to a hospital, you will pay cost-sharing as described in the "Inpatient hospital care" section in this benefit chart.

You pay these amounts until you reach the out-of-pocket maximum.

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

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished innetwork. Emergency coverage provided within the United States according to Medicare coverage guidelines.	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.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	\$0 copayment for each Medicare-covered exam in a nursing home. †† 20% coinsurance for each Medicare-covered exam outside of a nursing home. †† You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum.
Hearing services - routine hearing exam We cover 1 in or out-of-network hearing exam every year.	\$0 copayment	30% coinsurance*

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Hearing services - hearing aids	Provided by: UnitedHealthcare Hearing	
Through UnitedHealthcare Hearing, you can choose from a broad selection of over-the-counter (OTC) and prescription hearing aids. This includes brand-name manufacturers, as well as Relate®, UnitedHealthcare Hearing's private-label brand that offers affordable, high-quality hearing aids with a variety of technology options and helpful features. Hearing aids can be fit in-person with a network provider or delivered directly to you (select products only) This benefit is limited to 2 hearing aids every year. Hearing aid accessories, additional batteries and optional services are available for purchase, but they are not covered by the plan. You can get more information by viewing the Vendor Information Sheet at MyUHCMedicare.com or by calling Customer Service to have a paper copy sent to you.	You must obtain prior auth UnitedHealthcare Hearing. for optional follow-up visits: Home-delivered hearing aid through UnitedHealthcare only). Hearing aids purchased ou Hearing are not covered.	orization from Additional fees may apply ds are available nationwide Hearing (select products
Hearing aids purchased outside of UnitedHealthcare Hearing are not covered.		
HIV screening	There is no coinsurance, copayment, or deductible for members	30% coinsurance for members eligible for Medicare-covered

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: One screening exam every 12 months For women who are pregnant, we cover: Up to three screening exams during a pregnancy	eligible for Medicare- covered preventive HIV screening.	preventive HIV screening. You pay these amounts until you reach the outof-pocket maximum.
Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) Physical therapy, occupational therapy, and speech therapy Medical and social services Medical equipment and supplies	\$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met. ^{††} Other copayments or coinsurance may apply (Please see Durable medical equipment and related supplies for applicable copayments or coinsurance).	30% coinsurance for all home health visits provided by a 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 are covered for you What you must pay What you must pay when you get these when you get these services In-Network services Out-of-Network Home infusion therapy You will pay the cost-You will pay the costsharing that applies to sharing that applies to Home infusion therapy involves the primary care services, primary care services, intravenous or subcutaneous specialist physician specialist physician administration of drugs or biologicals services, or home health services, or home health to an individual at home. The (as described under (as described under components needed to perform home "Physician/practitioner "Physician/practitioner infusion include the drug (for example, services, including services, including antivirals, immune globulin), doctor's office visits" or doctor's office visits" or equipment (for example, a pump), and "Home health agency "Home health agency supplies (for example, tubing and care") depending on care") depending on catheters). where you received where you received Covered services include, but are not administration or administration or limited to: monitoring services.^{††} monitoring services. Professional services, including nursing services, furnished in See "Durable medical See "Durable medical accordance with the plan of care equipment" earlier in this equipment" earlier in this Patient training and education not chart for any applicable chart for any applicable otherwise covered under the cost-sharing for cost-sharing for durable medical equipment equipment and supplies equipment and supplies benefit related to home infusion related to home infusion therapy. †† therapy. □Remote monitoring Monitoring services for the See "Medicare Part B See "Medicare Part B provision of home infusion therapy prescription drugs" later prescription drugs" later and home infusion drugs in this chart for any in this chart for any furnished by a qualified home applicable cost-sharing applicable cost-sharing infusion therapy supplier for drugs related to for drugs related to home infusion home infusion therapy. therapy.†† **Hospice care** When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and You are eligible for the hospice benefit Part B services related to your terminal prognosis are when your doctor and the hospice medical director have given you a

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.	paid for by Original Medica Home Plan EX-F003 (PPO I	•
Covered services include: Drugs for symptom control and pain relief Short-term respite care		
☐Home care		
When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.		
For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Medicare pays for. You will be billed Original Medicare cost-sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization): If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services		
For services that are covered by UHC Nursing Home Plan EX-F003 (PPO I-SNP) but are not covered by Medicare Part A or B: UHC Nursing Home Plan EX-F003 (PPO I-SNP) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost-sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (What if you're in Medicare-certified hospice). Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.		
Immunizations Covered Medicare Part B services include: Pneumonia vaccines Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B COVID-19 vaccines	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.	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.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Other vaccines if you are at risk and they meet Medicare Part B coverage rules		
We also cover most other adult vaccines under our Part D prescription drug benefit, such as shingles or RSV vaccines. Refer to Chapter 6, Section 8 for additional information.		
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	\$2,000 copayment for each Medicare-covered hospital stay. Up to 90 days per benefit period are covered, plus an additional 60 lifetime reserve days. ^{††}	\$2,000 copayment for each Medicare-covered hospital stay. Up to 90 days per benefit period are covered, plus an additional 60 lifetime reserve days.
day before you are discharged is your last inpatient day. Covered services include, but are not limited to:	You pay these amounts until you reach the out-of-pocket maximum. Medicare benefit periods	You pay these amounts until you reach the outof-pocket maximum. Medicare benefit periods
□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	apply. 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	apply. 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

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□Necessary surgical and medical supplies □Use of appliances, such as wheelchairs □Operating and recovery room costs □Physical, occupational, and speech language therapy □Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. The plan has a network of facilities that perform organ transplants. The plan's hospital network for organ transplant services is different than the network shown in the 'Hospitals' section of your provider directory. Some hospitals in the plan's network for other medical services are not in the plan's network for transplant services. For information on network facilities for transplant services, please call UHC Nursing Home Plan EX-F003 (PPO I-SNP) Customer Service at 1-800-711-0646 TTY 711. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant.	has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. If you get authorized inpatient care at an outof-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.	has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If UHC Nursing Home Plan EX-F003 (PPO I-SNP) provides transplant services at a location outside of the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. While you are receiving care at the distant location, we will also reimburse transportation costs to and from the hospital or doctor's office for evaluations, transplant services and follow-up care. (Transportation in the distant location includes, but is not limited to: vehicle mileage, economy/ coach airfare, 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 that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
services are not subject to the daily limit amount. Blood - including storage and administration. Coverage begins with the first pint of blood that you need. Physician services		
Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "outpatient observation" stay. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.
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/publications/11435-Medicare-Hospital-Benefits.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.		
Inpatient services in a psychiatric hospital	\$2,000 copayment for each Medicare-covered	\$2,000 copayment for each Medicare-covered

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Covered services include: Mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. Inpatient substance use disorder services	hospital stay, up to 90 days per benefit period. Plus an additional 60 lifetime reserve days. †† You pay these amounts until you reach the outof-pocket maximum. Medicare benefit periods apply. 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.	hospital stay, 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 benefit periods apply. 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.
Inpatient stay: covered services received in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not	When your stay is no longer covered, these services will be covered as described in the following sections:	When your stay is no longer covered, these services will be covered as described in the following sections:

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:		
□Physician services	Please refer below to Physician/practitioner services, including doctor's office visits.	Please refer below to Physician/practitioner services, including doctor's office visits.
Diagnostic tests (like lab tests)	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
X-ray, radium, and isotope therapy including technician materials and services	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
□Surgical dressings □Splints, casts and other devices used to reduce fractures and dislocations	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.	Please refer below to Outpatient diagnostic tests and therapeutic services and supplies.
Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body	Please refer below to prosthetic and orthotic devices and related supplies.	Please refer below to prosthetic and orthotic devices and related supplies.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
organ, including replacement or repairs of such devices		
Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	Please refer below to prosthetic and orthotic devices and related supplies.	Please refer below to prosthetic and orthotic devices and related supplies.
Physical therapy, speech language therapy, and occupational therapy	Please refer below to Outpatient rehabilitation services.	Please refer below to Outpatient rehabilitation services.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	30% coinsurance for members eligible for Medicare-covered medical nutrition therapy services. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Medicare diabetes prevention program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B Prescription Drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: Drugs that usually aren't selfadministered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan	\$0 copayment for Medicare-covered Part B allergy antigens.†† 20% coinsurance for each Medicare-covered chemotherapy drug and the administration of that drug. You may pay less for certain rebatable drugs. This list and the cost of each rebatable drug changes every quarter.†† You pay these amounts until you reach the out-of-pocket maximum. 20% coinsurance for all other Medicare-covered Part B drugs.†† You may pay less for certain rebatable drugs. This list	\$0 copayment for Medicare-covered Part B allergy antigens. 30% coinsurance for each Medicare-covered chemotherapy drug and the administration of that drug. You pay these amounts until you reach the out-of-pocket maximum. 30% coinsurance for all other Medicare-covered Part B drugs. For the administration of these drugs, you will pay the cost-sharing that applies to primary care provider services, or outpatient hospital services (as

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment □Clotting factors you give yourself by injection if you have hemophilia □Transplant/Immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them □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 □Some Antigens (for allergy shots): Medicare covers antigens if a doctor prepares them and a properly instructed person (who	and the cost of each rebatable drug changes every quarter. For the administration of these drugs, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you received drug administration or infusion services. You will pay a maximum of \$35 for each 1-month supply of Part B covered insulin. You pay these amounts until you reach the out-of-pocket maximum.	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.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
could be you, the patient) gives them under appropriate supervision		
□Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does □Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer		
chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug		
Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it		
Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar®		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics □ Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycolepoetin beta) □ Intravenous Immune Globulin for the home treatment of primary		
immune deficiency diseases Parenteral and enteral nutrition (intravenous and tube feeding)		
Chemotherapy Drugs, and the administration of chemotherapy drugs		
The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://www.medicare.uhc.com/medicare/member/documents/part-b-step-therapy.html		
You or your doctor may need to provide more information about how a Medicare Part B prescription drug is used in order to determine coverage. There may be effective, lower-cost		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
drugs that treat the same medical condition. If you are prescribed a new Part B medication or have not recently filled the medication under Part B, you may be required to try one or more of these other drugs before the plan will cover your drug. If you have already tried other drugs or your doctor thinks they are not right for you, you or your doctor can ask the plan to cover the Part B drug. (For more information, see Chapter 9, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).) Please contact Customer Service for more information.		
We also cover some vaccines under our Part B and most adult vaccines under our Part D prescription drug benefit.		
Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.		
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	30% coinsurance for preventive obesity screening and therapy. You pay these amounts until you reach the out-
help you lose weight. This counseling is covered if you get it in a primary care		of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.		
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. Dispensing and administration of MAT medications (if applicable) Substance use disorder counseling Individual and group therapy Toxicology testing Intake activities Periodic assessments	\$0 copayment for Medicare-covered opioid treatment program services.††	\$0 copayment for Medicare-covered opioid treatment program services.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to:		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□X-rays	\$0 copayment for each Medicare-covered standard X-ray service. ^{††}	30% coinsurance for each Medicare-covered standard X-ray service. You pay these amounts until you reach the out-of-pocket maximum.
Radiation (radium and isotope) therapy including technician materials and supplies	20% coinsurance for each Medicare-covered radiation therapy service. †† You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each Medicare-covered radiation therapy service. You pay these amounts until you reach the out-of-pocket maximum.
□Surgical supplies, such as dressings □Splints, casts, and other devices used to reduce fractures and dislocations Note: There is no separate charge for medical supplies routinely used in the course of an office visit and included in the provider's charges for that visit (such as bandages, cotton swabs, and other routine supplies.) However, supplies for which an appropriate separate charge is made by providers (such as, chemical agents used in certain diagnostic procedures) are subject to cost-sharing as shown.	20% coinsurance for each Medicare-covered medical supply. †† You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each Medicare-covered medical supply. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□ Supplies, enteral nutrition	\$0 copayment for each Medicare-covered enteral nutrition supply. ^{††}	30% coinsurance for each Medicare-covered enteral nutrition supply.+ You pay these amounts until you reach the out-of-pocket maximum.
□Laboratory tests	\$0 copayment for Medicare-covered lab services. ^{††}	\$0 copayment for Medicare-covered lab services.
□Blood - including storage and administration (this means processing and handling of blood). Coverage begins with the first pint of blood that you need. □In addition, for the administration of blood infusion, you will pay the cost-sharing as described under the following sections of this chart, depending on where you received infusion services: □ Physician/practitioner services, including doctor's office visits □ Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers	\$0 copayment for Medicare-covered blood services in a nursing home. ^{††} 20% coinsurance for Medicare-covered blood services outside of a nursing home. ^{††} You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for Medicare-covered blood services. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Other outpatient diagnostic tests - non-radiological diagnostic services	\$0 copayment for Medicare-covered non-radiological diagnostic services in a nursing home. ^{††} 20% coinsurance for each Medicare-covered non-radiological diagnostic services outside of a nursing home. ^{††} 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.	30% coinsurance 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.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Other outpatient diagnostic tests - radiological diagnostic services, not including x-rays.	\$0 copayment for Medicare-covered radiological diagnostic services, not including X-rays in a nursing home.†† 20% coinsurance for Medicare-covered radiological diagnostic services, not including X-rays, outside of a nursing home.†† 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).	30% coinsurance for Medicare-covered radiological diagnostic services, not including X-rays. You pay these amounts until you reach the out-of-pocket maximum. The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at medicare.gov/publications/ 11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
numbers for free, 24 hours a day, 7days a week.		
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to:		
Services in an emergency department	Please refer to Emergency Care.	Please refer to Emergency care.
Laboratory and diagnostic tests billed by the hospital	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
☐Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	Please refer to Outpatient mental health care.	Please refer to Outpatient mental health care.
□X-rays and other radiology services billed by the hospital	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.	Please refer to Outpatient diagnostic tests and therapeutic services and supplies.
☐Medical supplies such as splints and casts	Please refer to Outpatient diagnostic	Please refer to Outpatient diagnostic

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	tests and therapeutic services and supplies.	tests and therapeutic services and supplies.
□Certain screenings and preventive services	Please refer to the benefits preceded by the "Apple" icon.	Please refer to the benefits preceded by the "apple" icon.
Certain drugs and biologicals that you can't give yourself (Note: Self-administered drugs in an outpatient hospital are not usually covered under your Part B prescription drug benefit. Under certain circumstances, they may be covered under your Part D prescription drug benefit. For more information on Part D payment requests, see Chapter 7 Section 2.)	Please refer to Medicare Part B prescription drugs.	Please refer to Medicare Part B prescription drugs.
Services performed at an outpatient clinic	Please refer to Physician/practitioner services, including doctor's office visits.	Please refer to Physician/practitioner services, including doctor's office visits.
Outpatient surgery or observation	Please refer to Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.	Please refer to Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.

Services that are covered for you What you must pay What you must pay when you get these when you get these services In-Network services Out-of-Network Please refer to Medicare Please refer to Medicare Outpatient infusion therapy Part B prescription drugs Part B prescription drugs and Physician/ and Physician/ For the drug that is infused, you will practitioner services, practitioner services. pay the cost-sharing as described in including doctor's office including doctor's office "Medicare Part B prescription drugs" in visits or Outpatient visits or Outpatient this benefit chart. In addition, for the surgery and other surgery and other administration of infusion therapy medical services medical services drugs, you will pay the cost-sharing provided at hospital provided at hospital that applies to primary care provider outpatient facilities and outpatient facilities and services, specialist services, or ambulatory surgical ambulatory surgical outpatient hospital services (as centers. centers. described under "Physician/ practitioner services, including doctor's office visits" or "Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers" in this benefit chart) depending on where you received drug administration or infusion services. **Note:** Unless the provider has written Outpatient observation Outpatient observation an order to admit you as an inpatient to cost-sharing is explained cost-sharing is explained the hospital, you are an outpatient and in Outpatient surgery in Outpatient surgery pay the cost-sharing amounts for and other medical and other medical outpatient hospital services. Even if services provided at services provided at you stay in the hospital overnight, you hospital outpatient hospital outpatient might still be considered an facilities and ambulatory facilities and ambulatory "outpatient." This is called an surgical centers. surgical centers. "outpatient observation" stay. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at medicare.gov/publications/11435-Medicare-Hospital-Benefits.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 mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	\$0 copayment for each Medicare-covered individual therapy session in a nursing home. †† 20% coinsurance for each Medicare-covered individual therapy session outside of a nursing home. †† \$0 copayment for each Medicare-covered group therapy session in a nursing home. †† 20% coinsurance for each Medicare-covered group therapy session outside of a nursing home. †† You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each Medicare-covered individual therapy session. 30% coinsurance for each Medicare-covered group therapy session. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, physician offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	\$0 copayment for each Medicare-covered physical therapy and speech-language therapy visit.†† \$0 copayment for each Medicare-covered occupational therapy visit.††	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. 30% coinsurance for each Medicare-covered occupational therapy visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Outpatient substance use disorder services Outpatient treatment and counseling for substance use disorder.	\$0 copayment for each Medicare-covered individual therapy session in a nursing home. †† 20% coinsurance for each Medicare-covered individual therapy session outside of a nursing home. †† \$0 copayment for each Medicare-covered group therapy session in a nursing home. 20% coinsurance for each Medicare-covered group therapy session outside of a nursing home. 20% coinsurance for each Medicare-covered group therapy session outside of a nursing home. †† You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each Medicare-covered individual therapy session. 30% coinsurance for each Medicare-covered group therapy session. You pay these amounts until you reach the out-of-pocket maximum.
Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient	\$0 copayment for a colonoscopy at an ambulatory surgical center. ^{††} 20% 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	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.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
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	and physician or surgical charges. †† You pay these amounts until you reach the out- of-pocket maximum.	You pay these amounts until you reach the out-of-pocket maximum.
other than surgery, including but not limited to diagnostic tests, therapeutic services, prosthetics, orthotics, supplies or Part B drugs, there may be additional cost-sharing for those services or items. Please refer to the appropriate section in this chart for the additional service or item you received for the specific cost-sharing required. See "Colorectal cancer screening" earlier in this chart for screening and diagnostic colonoscopy benefit information.	\$0 copayment for a colonoscopy at an outpatient hospital. †† 20% 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. Outpatient surgical services that can be delivered in an available ambulatory surgery center must be delivered	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.
	in an ambulatory surgery center unless a hospital outpatient department is medically necessary.	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	20% coinsurance 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.	30% coinsurance for each day of Medicare-covered observation services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum.
Over-the-counter (OTC) credit	Quarterly credit is \$350	
With this benefit, you'll get a credit loaded to your UnitedHealthcare UCard® each quarter to buy covered OTC items. Credits are added on the first day of each quarter (in January, April, July and October) and expire on December 31.		
Covered items include brand name and generic OTC products like vitamins, bladder control pads and first aid products. The credit cannot be used to buy tobacco or alcohol.		
Home and bath safety devices	Combined with OTC credit amount	
You can also use your OTC credit on covered home and bath safety devices	Home shipped OTC products and home and bath safety devices are available nationwide.	

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
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.		
Visit the UCard Hub at MyUHCMedicare.com to find participating stores, check your balance or place an order online.		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Partial hospitalization services and Intensive outpatient services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor'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, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	\$0 copayment each day for Medicare-covered benefits.††	30% coinsurance each day for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.
Physician/practitioner services, including doctor's office visits Covered services include: Medically-necessary medical or surgical services furnished in a physician's office.	\$0 copayment for services from a primary care physician or under	30% coinsurance for services from a primary care physician or under

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	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).	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.
Medically-necessary medical or surgical services furnished in a certified ambulatory surgical center or hospital outpatient department.	See "Outpatient surgery" earlier in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.	See "Outpatient surgery" earlier in this chart for any applicable copayments or coinsurance amounts for ambulatory surgical center visits or in a hospital outpatient setting.
Consultation, diagnosis, and treatment by a specialist.	\$0 copayment in a nursing home for services from a specialist or under certain circumstances, treatment by a nurse practitioner or physician's assistant or other non-physician health care professional in a specialist's office (as allowed by Medicare).	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).

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
	20% coinsurance outside of a nursing home. You pay these amounts until you reach the out-of-pocket maximum.	You pay these amounts until you reach the out-of-pocket maximum.
Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment.	\$0 copayment for each Medicare-covered exam in a nursing home. †† 20% coinsurance for each Medicare-covered exam outside of a nursing home. †† You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum.
□Our plan covers certain telehealth services beyond Original Medicare, including: □ Additional virtual medical visits: □Urgently needed services □Primary care provider □Specialist □Other non-physician health care professional or a nurse practitioner □ Additional virtual visits for individual mental health therapy sessions:	\$0 copayment	Not covered out-of- network

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
□Outpatient mental health care		
Outpatient substance use disorder services		
☐You can access your virtual mental health visits even if you haven't had an inperson visit previously		
☐ Virtual visits are medical or mental health visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/video capabilities.		
☐ You have the option of getting these services through an inperson visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth.		
Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment.		
☐ Telehealth services not covered by Medicare and not listed above are not covered.		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
☐ Medicare-covered telehealth services including: ☐ Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home.	\$0 copayment for each Medicare-covered visit.††	You will pay the cost- sharing that applies to a Medicare-covered in- office visit.
☐ Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location.		
☐ Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location.		
 Telehealth services for diagnosis, evaluation, and treatment of mental health disorders 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.		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
☐ Telehealth services provided by rural health clinics and federally qualified health centers.		
 Medicare-covered remote monitoring services. 		
□ Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:		
□You're not a new patient and		
☐The check-in isn't related to an office visit in the past 7 days and		
☐The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment.		
 Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: 		
□You're not a new patient and		
☐The evaluation isn't related to an office visit in the past 7 days and		
□The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment.		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
☐ Consultation your doctor has with other doctors by phone, internet, or electronic health record.		
Second opinion prior to surgery.	You will pay the cost- sharing that applies to specialist services (as described under "Physician/practitioner services, including doctor's office visits" above). ^{††}	You will pay the cost- sharing that applies to specialist services (as described under "Physician/practitioner services, including doctor's office visits" above).
Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, oral exams before a kidney transplant or services that would be covered when provided by a physician). Dental services provided by a dentist in connection with care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not Medicare-covered benefits and not covered under this benefit.	\$0 copayment for each Medicare-covered visit in a nursing home. ^{††} 20% coinsurance for each Medicare-covered visit outside of a nursing home. ^{††} You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Monitoring services in a physician's office or outpatient hospital setting if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as 'Coumadin Clinic' services).	You will pay the cost- sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitioner services, including doctor's office visits" or "Outpatient hospital services" in this benefit chart) depending on where you receive services. ^{††}	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.
Podiatry services Covered services include: Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). Routine foot care for members with certain medical conditions affecting the lower limbs.	\$0 copayment for each Medicare-covered visit in a nursing home. ^{††} 20% coinsurance for each Medicare-covered visit outside of a nursing home. ^{††} You pay these amounts until you reach the out-of-pocket maximum.	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.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Additional routine foot care We cover 8 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.	\$0 copayment for each routine visit.	30% coinsurance for each routine visit.*
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: Digital rectal exam Prostate Specific Antigen (PSA) test	\$0 copayment for each Medicare-covered digital rectal exam in a nursing home. 20% coinsurance for each Medicare-covered digital rectal exam outside of a nursing home. You pay these amounts until you reach the out-of-pocket maximum. There is no coinsurance, copayment, or deductible for an annual PSA test. Diagnostic PSA exams are subject to cost-sharing as described under Outpatient diagnostic tests and therapeutic services and supplies in this chart.	30% coinsurance for each Medicare-covered digital rectal exam. You pay these amounts until you reach the out-of-pocket maximum. 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 are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision services" later in this section for more detail.	20% coinsurance for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies.†† You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Medicare covers up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of pulmonary rehabilitation services.	\$0 copayment for each Medicare-covered pulmonary rehabilitative visit in a nursing home. ^{††} 20% coinsurance for each Medicare-covered pulmonary rehabilitative visit outside of a nursing home. ^{††} You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each Medicare-covered pulmonary rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening per year for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	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.
Screening for lung cancer with low dose computed tomography (LDCT)	There is no coinsurance, copayment, or deductible for the Medicare-covered	30% coinsurance for the Medicare-covered counseling and shared

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
For qualified individuals, a LDCT is covered every 12 months. Eligible members are: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive an order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screening: the member must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	counseling and shared decision making visit or for the LDCT.	decision making visit or for the LDCT. You pay these amounts until you reach the out-of-pocket maximum.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and	30% coinsurance for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	counseling for STIs preventive benefit.	You pay these amounts until you reach the out-of-pocket maximum.
Services to treat kidney disease Covered services include:		
Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.	\$0 copayment for Medicare-covered benefits.	30% coinsurance for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	\$0 copayment for Medicare-covered benefits in a nursing home. ^{††} 20% coinsurance for Medicare-covered benefits outside of a nursing home. ^{††} You pay these amounts until you reach the out-of-pocket maximum.	20% coinsurance for Medicare-covered benefits. You pay these amounts until you reach the outof-pocket maximum.
Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)	\$0 copayment for Medicare-covered benefits.	30% coinsurance for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.
□npatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)	These services will be covered as described in the following sections: Please refer to Inpatient hospital care.	These services will be covered as described in the following sections: Please refer to Inpatient hospital care.
☐Home dialysis equipment and supplies	Please refer to Durable medical equipment and related supplies.	Please refer to Durable medical equipment and related supplies.
Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in	Please refer to Home health agency care.	Please refer to Home health agency care.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
emergencies, and check your dialysis equipment and water supply)		
Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."		
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this document. Skilled nursing facilities are sometimes called "SNFs.") Covered services include, but are not limited to: Semiprivate room (or a private room if medically necessary) Meals, including special diets Skilled nursing services Physical therapy, occupational therapy, and speech language therapy Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) Blood - including storage and administration. Coverage begins	\$0 copayment each day for Medicare-covered SNF care, up to 100 days.†† You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is	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. 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

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
with the first pint of blood that you need. Medical and surgical supplies ordinarily provided by SNFs Laboratory tests ordinarily provided by SNFs X-rays and other radiology services ordinarily provided by SNFs Use of appliances such as wheelchairs ordinarily provided by SNFs Physician/practitioner services A 3-day prior hospital stay is not required. Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network costsharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).	no limit to the number of benefit periods you can have.	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.
☐A SNF where your spouse or domestic partner is living at the time you leave the hospital.		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, we cover two counseling quit attempts within a 12-month period as a preventive service. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	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.
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and have a referral from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: Consist of sessions lasting 30-60 minutes, comprising of a therapeutic exercise-training program for PAD in patients with claudication Be conducted in a hospital outpatient setting or a physician's office Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD	\$0 copayment for each Medicare-covered supervised exercise therapy (SET) visit in a nursing home. †† 20% coinsurance for each Medicare-covered supervised exercise therapy (SET) visit outside of a nursing home. †† You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for each Medicare-covered supervised exercise therapy (SET) visit. You pay these amounts until you reach the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.		
Routine transportation Details of this benefit: Up to 36 one-way trips, combined in and out-of-network, are covered each year (limited to ground transportation only). You are responsible for any costs over the trip limit both in and out-of-network. Trips must be to or from plan-approved locations, such as network providers, medical facilities and pharmacies. In addition, unlimited trips will be covered to and from dialysis centers within the plan service area. A trip is one-way transportation; a round trip is 2 trips.	\$0 copayment	75% coinsurance for covered services*

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
This benefit does not cover transportation by:		
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. Urgently needed services are provided within the United States according to Medicare coverage guidelines.	\$40 copayment for each vision You pay these amounts un pocket maximum.	
Vision services		

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Covered services include:		
□Outpatient physician services provided by an ophthalmologist or optometrist for the diagnosis and treatment of diseases and injuries of the eye, including diagnosis or treatment for age-related macular degeneration or cataracts. □Original Medicare doesn't cover routine eye exams (including eye	\$0 copayment for each Medicare-covered exam in a nursing home. ^{††} 20% coinsurance for each Medicare-covered exam outside of a nursing home. ^{††} You pay these amounts until you reach the out-	30% coinsurance for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum.
refractions) for eyeglasses/ contacts. See Vision services - routine eye exam coverage below.	of-pocket maximum.	
For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older.	\$0 copayment for Medicare-covered glaucoma screening in a nursing home. 20% coinsurance for Medicare-covered glaucoma screening outside of a nursing home. You pay these amounts until you reach the out-of-pocket maximum.	30% coinsurance for Medicare-covered glaucoma screening. You pay these amounts until you reach the out-of-pocket maximum.
For people with diabetes or signs and symptoms of eye disease, eye exams to evaluate for eye disease are covered per Medicare guidelines. Annual examinations by an ophthalmologist or	\$0 copayment for Medicare-covered eye exams to evaluate for eye disease in a nursing home. ^{††}	30% coinsurance for Medicare-covered eye exams to evaluate for eye disease.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
optometrist are recommended for asymptomatic diabetics. For people with diabetes, screening for diabetic retinopathy is covered once per year.	20% coinsurance for Medicare-covered eye exams to evaluate for eye disease outside of a nursing home. ^{††} You pay these amounts until you reach the out-of-pocket maximum.	You pay these amounts until you reach the out-of-pocket maximum.
One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (additional pairs of eyeglasses or contacts are not covered by Medicare). If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery. Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any upgrades are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating).	\$0 copayment for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.	\$0 copayment for one pair of Medicare-covered standard glasses or contact lenses after cataract surgery.
Vision services - routine eye exam We cover 1 in or out-of-network routine eye exam every year.	\$0 copayment	30% coinsurance*

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
Eye refraction is part of the routine eye exam benefit. You can get more information by viewing the Vendor Information Sheet at MyUHCMedicare.com or by calling Customer Service to have a paper copy sent to you.		
Vision services - routine eyewear ☐ pair of standard lenses and frames every year Or ☐ Contact lenses instead of lenses and frames every year Once contact lenses are selected and fitted, they may not be exchanged for eyeglasses. The plan will pay up to the amount shown for covered frames or contact lenses. You are responsible for any costs after that. Options that are not covered include (but are not limited to) non-prescription eyewear, upgraded progressive lenses, blended bifocal, Hi Index, tinting, UV or anti-reflective coating, and polycarbonate.	Frames or contact lenses \$0 copayment Plan pays up to \$300 toward of frames (with standard lenses (fitting and eadditional cost). Lenses Standard lenses that are convision, lined bifocal, lined to 1 (standard) progressive lenses through UnitedHealthcare is only).	rd your purchase of 1 pair nses covered in full) or evaluation may be an overed in full include single rifocal, lenticular, and Tier nses.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
This benefit may not be combined with any in-store promotional offer, such as a 2-for-1 sale, discount, or coupon. You can get more information by viewing the Vendor Information Sheet at MyUHCMedicare.com or by calling Customer Service to have a paper copy sent to you.		
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this medical benefits chart. Important: We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. \$0 copayment for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" preventive visit in a nursing home. 20% coinsurance for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" preventive visit outside of a nursing home. Please refer to outpatient diagnostic tests and therapeutic	30% coinsurance for the "Welcome to Medicare" preventive visit. You pay these amounts until you reach the outof-pocket maximum. 30% coinsurance for a one-time Medicare-covered EKG screening if ordered as a result of your "Welcome to Medicare" preventive visit. Please refer to Outpatient diagnostic tests and therapeutic services and supplies for other EKG's. You pay these amounts until you reach the outof-pocket maximum.

Services that are covered for you	What you must pay when you get these services In-Network	What you must pay when you get these services Out-of-Network
"Welcome to Medicare" preventive visit.	services and supplies for other EKG's. You pay these amounts until you reach the outof-pocket maximum.	

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

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

Covered Routine Dental Benefits Included with Your Plan: Annual Maximum: \$3,250 ☐ As a part of your UnitedHealthcare Medicare Advantage plan you get a routine dental benefit that provides coverage for non-Medicare covered preventive and other necessary dental services such as: Exams Cleanings (prophylaxis & periodontal maintenance) Fillings X-rays o Crowns Bridges Root canals Extractions Partial dentures Complete dentures Implants ☐ Some covered services may consider prior tooth history and procedures in conjunction with frequency limitations. If you wish to discuss detailed information about your plan with your dentist or see the full list of covered dental services with associated frequency limitations, you can find it in the UHC Dental Medicare quick reference guide at uhcmedicaredentalprovidergrg.com. ☐ Procedures used for cosmetic-only reasons (tooth bleaching/whitening, veneers, gingival recontouring, enamel microabrasion), orthodontics, space maintenance, sales tax, charges for failure to keep appointments, dental case management, dental charges related to COVID screening, testing and vaccination, and unspecified procedures by report are not covered by the plan. ☐ After the annual maximum is exhausted, any remaining charges are your responsibility. Other limitations and exclusions are listed below. ☐ This dental plan offers access to the robust UHC Dental National Medicare Advantage Network. Network dentists have agreed to provide services at a negotiated rate. If you see

a network dentist, you cannot be billed more than that rate for covered services within the

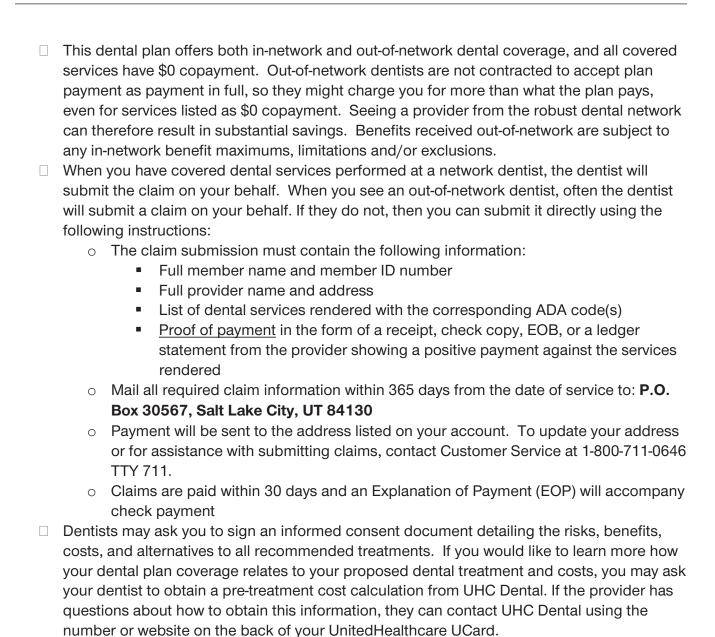
MyUHCMedicare.com. You may also call 1-800-711-0646 for help with finding a provider or

limitations of the plan. Any fees associated with non-covered services are your

☐ For assistance finding a provider, please use the dental provider search tool at

responsibility.

scheduling a dental appointment



Exclusions:

MyUHCMedicare.com

1. Services performed by an out-of-network dentist if your plan does not have out-of-network coverage.

☐ For all other questions or more information, please call 1-800-711-0646 TTY 711 or visit

- 2. Dental services that are not necessary.
- 3. Hospitalization or other facility charges.
- 4. Any dental procedure performed solely for cosmetic and/or aesthetic reasons.
- 5. Any dental procedure not directly associated with a dental disease.
- 6. Any procedure not performed in a dental setting.
- 7. Reconstructive surgery of any type, including reconstructive surgery related to a dental disease, injury, or congenital anomaly.
- 8. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on dental therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
- 9. Service for injuries or conditions covered by workmen's compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county, or other political subdivision. This exclusion does NOT apply to any services covered by Medicaid or Medicare.
- 10. Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
- 11. Dental services rendered (including otherwise covered dental services) after the date on which individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date on which individual coverage under the policy terminates.
- 12. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.
- 13. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice, sales tax, or duplicating/copying patient records.
- 14. Tooth bleaching and/or enamel microabrasion
- 15. Veneers
- 16. Orthodontics
- 17. Sustained release of therapeutic drug (D9613)
- 18. COVID screening, testing, and vaccination
- 19. Charges aligned to dental case management, case presentation, consultation with other medical professionals or translation/sign language services.

- 20. Space maintenance
- 21. Any unspecified procedure by report (Dental codes: D##99)

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

Section 3 What services are not covered by the plan?

Section 3.1 Services we do not cover (exclusions)

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

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

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

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

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

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Naturopath services (uses natural or alternative treatments).	Not covered under any condition	
Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport)		Services are only covered when the ambulance pick-up address is located in rural New York and applicable conditions are met. Members are responsible for all paramedic intercept service costs that occur outside of rural New York.
Optional, additional, or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including but not limited to home and car remodeling or modification, and exercise equipment.	Not covered under any condition	
Immunizations for foreign travel purposes.	Not covered under any condition	
Requests for payment (asking the plan to pay its share of the costs) for covered drugs sent after 36 months of getting your prescription filled.	Not covered under any condition	
Equipment or supplies that condition the air, heating pads, hot water bottles, wigs and their care, and other primarily nonmedical equipment.	Not covered by Medicare under any condition	Disposable or nonreusable items such as incontinence supplies are not covered under Medicare but may be covered under the OTC benefit.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
For transplants: items not covered include, but are not limited to the below.	Not covered under any condition	
For transportation: Vehicle rental, purchase, or maintenance/repairs Auto clubs (roadside assistance) Gas Travel by air or ground ambulance (may be covered under your medical benefit). Air or ground travel not related to medical appointments Parking fees incurred other than at lodging or hospital For lodging: Deposits Utilities (if billed separate from the rent payment) Phone calls, newspapers, movie rentals and gift cards		
Expenses for lodging when staying with a relative or friend Meals		
Self-administered drugs in an outpatient hospital		Covered only under specific conditions.

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

In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral/mental health. When clinical

necessity requires a rapid determination of the safe and effective use of a new technology or new application of an existing technology for an individual member, one of our medical directors makes a medical necessity determination based on individual member medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

Chapter 5

Using the plan's coverage for Part D prescription drugs

Section 1 Introduction

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

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

The plan will generally cover your drugs as long as you follow these basic rules:
You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, which must be valid under applicable state law.
Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter or you can fill your prescription through the plan's mail-order service.)
Your drug must be on the plan's List of Covered Drugs (Formulary) (we call it the Drug List for short). (See Section 3 in this chapter.)
Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 in this chapter for more information about a medically accepted indication.)
Your drug may require approval before we will cover it. (See Section 4 in this chapter for more

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

Section 2.1 Use a network pharmacy

information about restrictions on your coverage.)

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

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

You may go to any of our network pharmacies.

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

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

What if you need a specialized pharmacy?

Section 2.3 Using the plan's mail-order service

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

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

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

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

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

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

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

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

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

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 10 days before your current prescription will run out. This will ensure your order is shipped to you in time.

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

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

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

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

When you get a long-term supply of drugs, your cost-sharing may be lower. The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

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

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

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy **only** when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where

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

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

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

How do you ask for reimbursement from the plan?

outpatient surgery, or other outpatient setting.

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

Section 3 Your drugs need to be on the plan's Drug List Section 3.1 The Drug List tells which Part D drugs are covered

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

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

The drugs on the Drug List are only those covered under Medicare Part D.

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

□Approved by the Food	and Drug A	Administration	for the	diagnosis	or cor	ndition fo	or which	ı it is
being prescribed, or								

□Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

See Chapter 12 for definitions of the types of drugs that may be on the Drug List.

What is not on the Drug List?

The plan does not cover all prescription drugs.

□ In some cases, the law does not allow any Medicare plan to cover certain types of drugs. (For
more information about this, see Section 7.1 in this chapter.)
□ In other cases, we have decided not to include a particular drug on the Drug List. In some

cases, you may be able to obtain a drug that is not on the Drug List. (For more information, please see Chapter 9.)

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

You have four ways to find out:

- 1. Check the most recent Drug List we provided electronically.
- 2. Visit the plan's website (MyUHCMedicare.com). The Drug List on the website is always the most current.
- 3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.
- 4. Use the plan's "Real-Time Benefit Tool" (MyUHCMedicare.com or by calling Customer Service). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

Section 4 There are restrictions on coverage for some drugs Section 4.1 Why do some drugs have restrictions?

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

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

Section 4.2 What kinds of restrictions?

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

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9)

What is a compounded drug?

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

Does my Part D plan cover compounded drugs?

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

- 1. Contains at least one FDA, or Compendia, approved drug ingredient, and all ingredients in the compound (including their intended route of administration) are supported in the Compendia.
- 2. Does not contain a non-FDA approved or Part D excluded drug ingredient
- 3. Does not contain an ingredient covered under Part B. (If it does, the compound may be covered under Part B rather than Part D)
- 4. Prescribed for a medically accepted condition

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

Compound Type	Medicare Coverage
Compound containing a Part B eligible ingredient	Compound is covered only by Part B

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

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

A compounded drug that is Part D eligible may require an approved coverage determination to be covered by your plan.

Getting plan approval in advance

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

Trying a different drug first

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

Quantity limits

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

Section 5	What if one of your drugs is not covered in the way you'd like it to be covered?
Section 5.1	There are things you can do if your drug is not covered in the way you'd like it to be covered

	where there is a prescription drug you are taking, or one that you and your hould be taking, that is not on our drug list (formulary) or is on our formulary r example:
	not be covered at all. Or maybe a generic version of the drug is covered but the sion you want to take is not covered.
☐The drug is cover explained in Sec	ered, but there are extra rules or restrictions on coverage for that drug, as ction 4.
•	s you can do if your drug is not covered in the way that you'd like it to be drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to can do.
Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
If your drug is not or	n the Drug List or is restricted, here are options:
□You may be able	e to get a temporary supply of the drug.
□You can change	to another drug.
☐You can request the drug.	t an exception and ask the plan to cover the drug or remove restrictions from
You may be able to	get a temporary supply
	nstances, the plan must provide a temporary supply of a drug that you are temporary supply gives you time to talk with your provider about the change.
•	remporary supply, the drug you have been taking must no longer be on the R is now restricted in some way.
□If you are a new of your member	member, we will cover a temporary supply of your drug during the first 90 days ship in the plan.
□If you were in the c	e plan last year, we will cover a temporary supply of your drug during the first alendar year.
days, we will allo prescription mus	supply will be for at least a 30-day supply. If your prescription is written for fewer ow multiple fills to provide up to at least a 30-day supply of medication. The st be filled at a network pharmacy. (Please note that the long-term care provide the drug in smaller amounts at a time to prevent waste.)
	bers who have been in the plan for more than 90 days and reside in a long-
We will cover at	ty and need a supply right away: least a 31-day emergency supply of a particular drug, or less if your ritten for fewer days. This is in addition to the above temporary supply.
There may be un hospitals) or lever long-term care fa	ent members with level of care changes: enplanned transitions such as hospital discharges (including psychiatric el of care changes (i.e., changing long-term care facilities, exiting and entering a acility, ending Part A coverage within a skilled nursing facility, or ending ge and reverting to Medicare coverage) that can occur anytime. If you are

prescribed a drug that is not on our Drug List or your ability to get your drugs is restricted in some way, you are required to use the plan's exception process. For most drugs, you may request a one-time temporary supply of at least 30 days to allow you time to discuss alternative treatment with your doctor or to request a Drug List (formulary) exception. If your doctor writes your prescription for fewer days, you may refill the drug until you've received at least a 30 day supply.

For questions about a temporary supply, call Customer Service.

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

1)You can change to another drug

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

2)You can ask for an exception

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

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 6 What if your coverage changes for one of your drugs? Section 6.1 The Drug List can change during the year Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the Drug List. For example, the plan might: Add or remove drugs from the Drug List. Add or remove a restriction on coverage for a drug. Replace a brand name drug with a generic version of the drug. Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change the plan's Drug List. See Chapter 12 for definitions of the drug types discussed in this chapter.

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

Information on changes to drug coverage

recognized by Medicare.

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. This section describes the types of changes we may m ar

make to the Drug List and when you will get direct notice if changes are made for a drug that you are taking.
Changes we may make to the Drug List that affect you during the current plan year
□Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.
□ When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be with the same or fewer restrictions.
We will make these immediate changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
We may make these changes immediately and tell you later, even if you are taking the drug that we are removing or making changes to. If you are taking the like drug at the time we make the change, we will tell you about any specific change we made.
□Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.
□ When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be with the same or fewer restrictions.
We will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
□ We will tell you at least 30 days before we make the change, or tell you about the change and cover at least a 30-day fill of the version of the drug you are taking.
□Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.
☐ Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you are taking that drug, we will tell you after we make the change.
 □ Making other changes to drugs on the Drug List □ We may make other changes once the year has started that affect drugs you are taking. For example, we might make changes based on FDA boxed warnings or new clinical guidelines

☐ We will tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you are taking.

If we make any of these changes to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or requesting a coverage decision to satisfy any new restrictions on the drug you are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, see Chapter 9.

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

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

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

\square We put a new restriction on the use of your dr	the use of your drug	use	on the	new restriction	∃We put a
--	----------------------	-----	--------	-----------------	-----------

□We remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. We will not tell you about these types of changes directly during the current plan year. You will need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

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

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

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

□Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare
Part A or Part B.
□Our plan cannot cover a drug purchased outside the United States or its territories.
□Our plan cannot cover off-label use of a drug when the use is not supported by certain
references, such as the American Hospital Formulary Service Drug Information and the
Micromedex DRUGDEX Information System. Off-label use is any use of the drug other than
those indicated on a drug's label as approved by the Food and Drug Administration.

lr	n addition, by law, the following categories of drugs are not covered by Medicare drug plans:
	□Non-prescription drugs (also called over-the-counter drugs).
	□Drugs used to promote fertility.
	□Drugs used for the relief of cough or cold symptoms.
	□Drugs used for cosmetic purposes or to promote hair growth.
	$\hfill\square Prescription$ vitamins and mineral products, except prenatal vitamins and fluoride preparations.
	□ Drugs used for the treatment of sexual or erectile dysfunction.
	□Drugs used for treatment of anorexia, weight loss, or weight gain.
	□Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

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

Section 8 Filling a prescription

Section 8.1 Provide your UnitedHealthcare member ID information

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

Section 8.2 What if you don't have your UnitedHealthcare member ID information with you?

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

Section 9	Part D drug coverage in special situations
Section 9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

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

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

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

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

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

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

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

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

Special note about 'creditable coverage':

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

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

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

Section 9.4 What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because they are unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your

hospice provider that the drugs are unrelated before our plan can cover the drugs. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

Section 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

□Possible medication errors
□ Drugs that may not be necessary because you are taking another similar drug to treat the same condition
□ Drugs that may not be safe or appropriate because of your age or gender
□Certain combinations of drugs that could harm you if taken at the same time
□ Prescriptions for drugs that have ingredients you are allergic to
□Possible errors in the amount (dosage) of a drug you are taking
□Unsafe amounts of opioid pain medications
we see a possible problem in your use of medications, we will work with your provider to correct

the problem.

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

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

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

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You will have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

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

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

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

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

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

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

Chapter 6

What you pay for your Part D prescription drugs



Are you currently getting help to pay for your drugs?

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

Section 1 Introduction

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

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

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

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

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

The "deductible" is the amount you pay for drugs before our plan begins to pay its share.

"Copayment" is a fixed amount you pay each time you fill a prescription.

"Coinsurance" is a percentage of the total cost you pay each time you fill a prescription.

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

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

Your out-of-pocket costs include the payments listed below (as long as they are for Part I drugs and you followed the rules for drug coverage that are explained in Chapter 5):	O covered
☐The amount you pay for drugs when you are in any of the following drug payment sta	aes:
☐ The Deductible Stage	J
☐ The Initial Coverage Stage	
□ Any payments you made during this calendar year as a member of a different Medica prescription drug plan before you joined our plan.	are
It matters who pays:	
☐ If you make these payments yourself, they are included in your out-of-pocket costs.	
□These payments are also included in your out-of-pocket costs if they are made on yo by certain other individuals or organizations . This includes payments for your druge a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, employer or union plans, TRICARE, or by the Indian Health Service. Payments made by Medicare's "Ext Program are also included.	s made by health
Moving on to the Catastrophic Coverage Stage:	
When you (or those paying on your behalf) have spent a total of \$2,000 in out-of-pocket of the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage.	
These payments are not included in your out-of-pocket costs	
Your out-of-pocket costs do not include any of these types of payments:	
□Your monthly premium	
□Drugs you buy outside the United States and its territories	
□Drugs that are not covered by our plan	
Drugs you get at an out-of-network pharmacy that do not meet the plan's requirement of-network coverage	ts for out-
of-network coverage □Non-Part D drugs, including prescription drugs covered by Part A or Part B and other	drugs
of-network coverage Non-Part D drugs, including prescription drugs covered by Part A or Part B and other excluded from coverage by Medicare Payments you make toward prescription drugs not normally covered in a Medicare P	drugs
of-network coverage Non-Part D drugs, including prescription drugs covered by Part A or Part B and other excluded from coverage by Medicare Payments you make toward prescription drugs not normally covered in a Medicare P Drug Plan	drugs rescription
of-network coverage Non-Part D drugs, including prescription drugs covered by Part A or Part B and other excluded from coverage by Medicare Payments you make toward prescription drugs not normally covered in a Medicare P Drug Plan Payments for your drugs that are made by the Veterans Health Administration (VA) Payments for your drugs made by a third-party with a legal obligation to pay for prescription.	drugs rescription

pocket costs for drugs, you are required to tell our plan by calling Customer Service.

How can you keep track of your out-of-pocket total? □ We will help you. The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches \$2,000, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage. ■ Make sure we have the information we need. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date. Section 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug Section 2.1 What are the drug payment stages for our plan members? There are three "drug payment stages" for your prescription drug coverage under UHC Nursing Home Plan EX-F003 (PPO I-SNP). How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 6 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

Section 3	We send you reports that explain payments for your drugs and which payment stage you are in
Section 3.1	We send you a monthly summary called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

We keep track of how much you have paid. This is called your out-of-pocket costs . This
includes what you paid when you get a covered Part D drug, any payments for your drugs
made by family or friends, and any payments made for your drugs by "Extra Help" from
Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug
assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs)

We keep track of your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

•	ne or more prescriptions filled through the plan during the previous month we will EOB. The Part D EOB includes:
have filled du	or that month. This report gives the payment details about the prescriptions you ring the previous month. It shows the total drug costs, what the plan paid, and others on your behalf paid.
	year since January 1. This is called "year-to-date" information. It shows the total d total payments for your drugs since the year began.
• •	formation. This information will display the total drug price, and any percentage first fill for each prescription claim of the same quantity.
	er cost alternative prescriptions. This will include information about other is with lower cost-sharing for each prescription claim, if applicable.
Section 3.2	Help us keep our information about your drug payments up to date
	your drug costs and the payments you make for drugs, we use records we get Here is how you can help us keep your information correct and up to date:
-	nitedHealthcare member ID card when you get a prescription filled. This helps we know about the prescriptions you are filling and what you are paying.
of a prescripti keep track of	e have the information we need. There are times you may pay for the entire cost on drug. In these cases, we will not automatically get the information we need to your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give hese receipts. Here are examples of when you should give us copies of your drug
	ourchase a covered drug at a network pharmacy at a special price or using a ard that is not part of our plan's benefit.
□ When you r assistance	nade a copayment for drugs that are provided under a drug manufacturer patient program.
, ,	ou have purchased covered drugs at out-of-network pharmacies or other times you he full price for a covered drug under special circumstances.
•	illed for a covered drug, you can ask our plan to pay our share of the cost. For son how to do this, go to Chapter 7, Section 2.
certain other i qualify you for Assistance Pr most charities	rmation about the payments others have made for you. Payments made by ndividuals and organizations also count toward your out-of-pocket costs and help r catastrophic coverage. For example, payments made by a State Pharmaceutical ogram, an AIDS drug assistance program (ADAP), the Indian Health Service, and a count toward your out-of-pocket costs. Keep a record of these payments and us so we can track your costs.
□ Check the wr sure the informal questions, ple	ritten report we send you. When you receive the Part D EOB, look it over to be mation is complete and correct. If you think something is missing or you have any ease call us at Customer Service. You can also view your EOB on our website at eare.com. Be sure to keep these reports.

Section 4 During the Deductible Stage, you pay the full cost of your drugs

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription for the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount, which is \$590 for 2025. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines. The **"full cost"** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you have paid \$590 for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

Section 5	During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share
Section 5.1	What you pay for a drug depends on the drug and where you fill your prescription

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

Your pharmacy choices

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

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

cover a prescription filled at an out-of-network pharmacy.

☐ The plan's mail-order pharmacy

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

Section 5.2 A table that shows your costs for a one-month supply of a drug

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

Your share of the cost when you get a one-month supply of a covered Part D prescription drug:

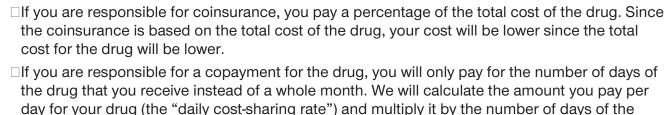
Tier	Standard retail cost- sharing (in-network) (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost- sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing for Covered Drugs ¹	25% coinsurance	25% coinsurance	25% coinsurance

¹ You will pay a maximum of \$35 for each 1-month supply of Part D covered insulin drugs through all drug payment stages, except the Catastrophic drug payment stage, where you pay \$0. Please see Section 8 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.

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

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

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



Section 5.4 A table that shows your costs for a long-term (100-day) supply of a drug

drug you receive.

For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is a 100-day supply.

The table below shows what you pay when you get a long-term (100-day) supply of a drug.

Your share of the cost when you get a long-term supply of a covered Part D prescription drug:

Tier	Standard retail cost-sharing (in-network) (100-day supply)	Mail-order cost-sharing (100-day supply)
Cost-Sharing for Covered Drugs ¹	25% coinsurance Some covered drugs limited to a 30-day supply	25% coinsurance Some covered drugs limited to a 30-day supply

¹ You will pay a maximum of \$105 for each 3-month supply of Part D covered insulin drugs through all drug payment stages, except the Catastrophic drug payment stage, where you pay \$0.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **\$2,000**. You then move on to the Catastrophic Coverage Stage.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf for your drugs during the year. Not all members will reach the \$2,000 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

Section 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

□You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this payment stage, you pay nothing for your covered Part D drugs.

Section 7 Additional benefits information

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

1. Medications will not be covered if prescribed by physicians or other providers who are excluded or precluded from the Medicare program participation.

- 2. If you opt into the Medicare Prescription Payment Plan, you will no longer pay the pharmacy when you fill a covered Part D prescription. Your plan will pay the pharmacy on your behalf and send you a monthly bill for your prescription drug costs. You will continue to receive a separate bill for your monthly plan premium if you have one. Be sure to pay each invoice separately and do not combine payments.
- 3. Claims covered under Part B or any additional coverage (non-Part D) are excluded from the Medicare Prescription Payment Plan.

Section 8 Part D Vaccines. What you pay for depends on how and where you get them

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your Part D deductible. Refer to your plan's Drug List or contact Customer Service for coverage and cost-sharing details about specific vaccines.

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

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

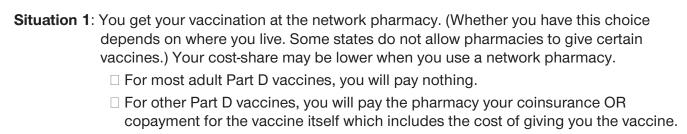
The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

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

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

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

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



☐ Our plar	will pay the remainder of the costs.
Situation 2: You get the behalf.	Part D vaccination at your doctor's office and they submit a claim on your
□ For othe copaym (Your do share.)	t adult Part D vaccines, you will pay nothing. r Part D vaccines, you will pay your doctor your coinsurance OR ent for the vaccine itself which includes the cost of giving you the vaccine. ector is not allowed to charge you more than your plan approved cost-
⊔ Our piar	will pay the remainder of the costs.
on your beh	Part D vaccine at your doctor's office and ask them not to submit a claim alf. (Your doctor is required to submit a claim unless you ask them not to.) iving you the vaccine, your doctor must tell you what your out-of-pocket I be.
-	bu get the vaccine, you may have to pay for the entire cost of the vaccine d the cost for the provider to give it to you.
	then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
For othe normal o less any	t adult Part D vaccines, you will be reimbursed the full amount you paid. It is a reimbursed the amount you paid less your coinsurance OR copayment for the vaccine (including administration), and difference between the amount the doctor charges and what we normally ou get "Extra Help," we will reimburse you for this difference.)
	Part D vaccine itself at your pharmacy, and then take it to your doctor's they give you the vaccine.
☐ For mos	t adult Part D vaccines, you will pay nothing for the vaccine itself.
	r Part D vaccines, you will have to pay the pharmacy your coinsurance OR ent for the vaccine itself.
administ	our doctor gives you the vaccine, they will submit a claim for the ration of the vaccine. Depending on which drug payment stage you're in, have to pay an additional coinsurance OR copayment.
service.	k your doctor not to submit a claim, you will pay the entire cost for this You can then ask our plan to pay our share of the cost by using the res described in Chapter 7.
For othe coinsura betweer	t adult Part D vaccines, you will be reimbursed the full amount you paid. It is a Part D vaccines, you will be reimbursed the amount you paid less any since OR copayment for the vaccine administration, and less any difference the amount the doctor charges and what we normally pay. (If you get elp," we will reimburse you for this difference.)

Chapter 7

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

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

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

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

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

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

When you received services from a provider in the United States who is not part of our network, you are only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill the plan for our share of the cost.

□Emergency providers are legally required to provide emergency car responsible for paying your share of the cost for emergency or urge you pay the entire amount yourself at the time you receive the care, for our share of the cost. Send us the bill, along with documentation have made.	ntly needed services. If ask us to pay you back
□ If you pay the entire amount yourself at the time you receive the care back for our share of the cost. Send us the bill, along with documen you have made.	
□You may get a bill from the provider asking for payment that you thin us this bill, along with documentation of any payments you have already the provider is owed anything, we will pay the provider directly.	•
□ If you have already paid more than your share of the cost of the se how much you owed and pay you back for our share of the cost.	ervice, we will determine
□ Please note: While you can get your care from an out-of-network pr must be eligible to participate in Medicare. Except for emergency ca provider who has opted out of or been excluded or precluded from	are, we cannot pay a

If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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

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

☐You only have to pay your cost-sharing amount when you get covered services. We do not
allow network providers to add additional separate charges, called "balance billing." This
protection (that you never pay more than your cost-sharing amount) applies even if we pay
the provider less than the provider charges for a service and even if there is a dispute and
we don't pay certain provider charges.
□Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
□ If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay

you back the difference between the amount you paid and the amount you owed under the plan.

3.If you are retroactively enrolled in our plan

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

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

	For example, the drug may not be on the plan's Drug List or it could have a requirement or
1	restriction that you didn't know about or don't think should apply to you. If you decide to get
1	the drug immediately, you may need to pay the full cost for it.
_	

□Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

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

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

□ Either download a copy of the form from our website (**MyUHCMedicare.com**) or call Customer Service and ask for the form.

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

Part D Prescription drug payment requests:

Optum Rx

P.O. Box 650287

Dallas, TX 75265-0287

Medical claims payment requests:

UnitedHealthcare

P.O. Box 31362

Salt Lake City, UT 84131-0362

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

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

Section 3 We will consider your request for payment and say yes or no Section 3.1 We check to see whether we should cover the service or drug and how much we owe

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

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is **not** covered, or you did **not** follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

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

Chapter 8

Your rights and responsibilities

Section 1 Our plan must honor your rights and cultural sensitivities as a member of the plan Section 1.1 You have a right to receive information about the organization, its services its practitioners and providers and member rights and

responsibilities. We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc.)

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

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

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

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

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

Sección 1.1

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

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

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

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

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

You have the right to choose a provider in the plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount. You also have the right to choose an out-of-network provider that participates in Medicare.

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

How to Receive Care After Hours

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

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

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

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

□Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

· · · · · · · · · · · · · · · · · · ·	and controlling how your health information is used. e of Privacy Practice, that tells about these rights your health information.
How do we protect the privacy of your health	information?
\square We make sure that unauthorized people do	n't see or change your records.
	if we intend to give your health information to ing for your care, we are required to get written given legal power to make decisions for you first.
□There are certain exceptions that do not recexceptions are allowed or required by law.	uire us to get your written permission first. These
We are required to release health information quality of care.	ation to government agencies that are checking on
your health information including informa Medicare releases your information for re	arough Medicare, we are required to give Medicare tion about your Part D prescription drugs. If search or other uses, this will be done according to y, this requires that information that uniquely

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

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

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

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

HEALTH PLAN NOTICE OF PRIVACY PRACTICES

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

Effective January 1, 2024

We¹ are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice that is currently in effect.

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

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

How We Collect, Use, and Disclose Information

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

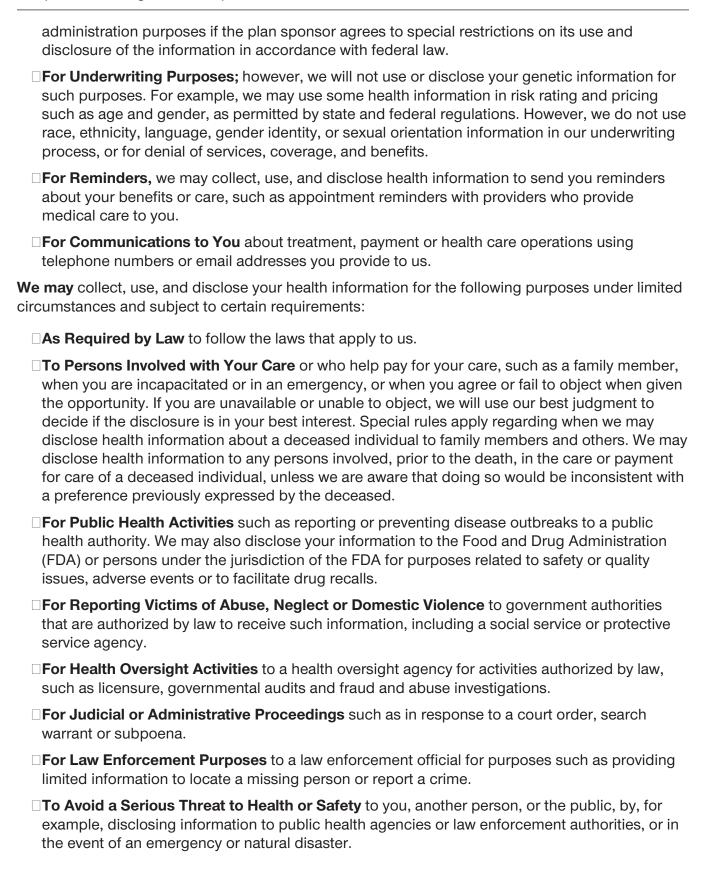
□To you or someone who has the legal right to act for you (your personal representative) in orde to administer your rights as described in this notice; and
☐ To the Secretary of the Department of Health and Human Services, if necessary, to confirm we
are meeting our privacy obligations.

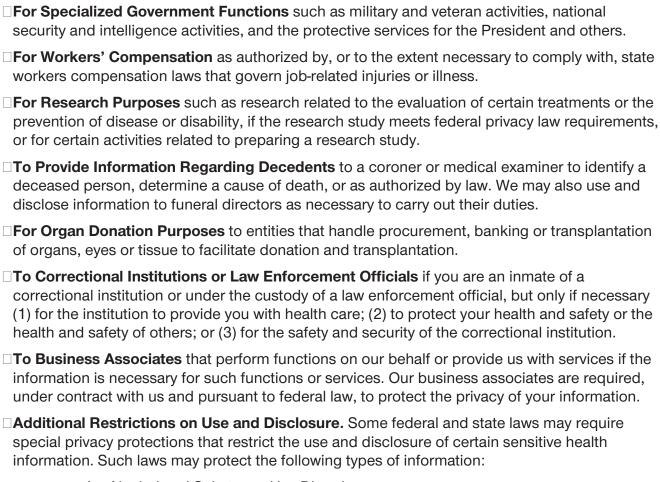
We may collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may collect, use, and disclose your health information:

- For Payment of premiums owed to us, to determine your health care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain medical procedures and what percentage of the bill may be covered.
- For Treatment, including to aid in your treatment or the coordination of your care. For example, we share information with other doctors to help them provide medical care to you.
- For Health Care Operations as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.

To Provide You Information on Health-Related Programs or Products such as alternative
medical treatments and programs or about health-related products and services, subject to
limits imposed by law.

For Plan Sponsors, if your coverage is through an employer sponsored group health plan. We
may share summary health information and enrollment and disenrollment information with the
plan sponsor. We also may share other health information with the plan sponsor for plan





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

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

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

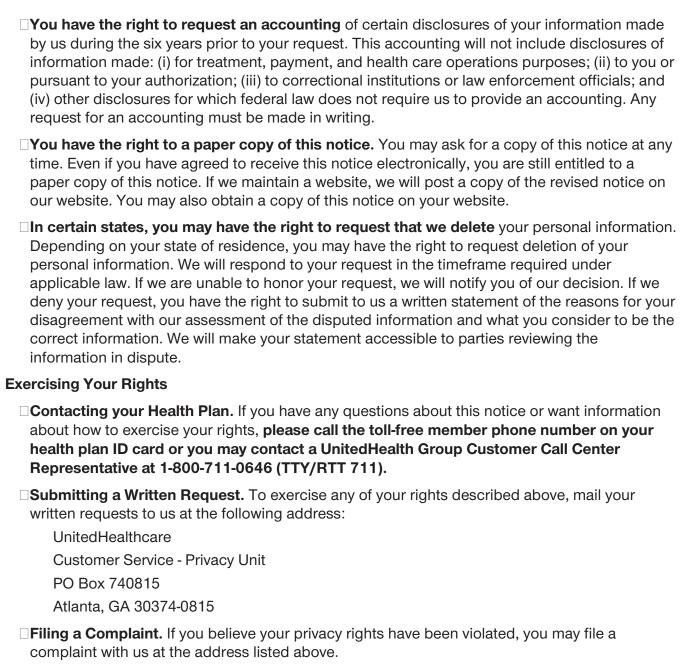
What Are Your Rights

to your health information.

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

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

your request. If we deny your request, you may have a statement of your disagreement added



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

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

Financial Information Privacy Notice

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

Effective January 1, 2024

We² are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:
□Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
□ Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
□Information from a consumer reporting agency.
Disclosure of Information
We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:
☐ To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
☐To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
☐ To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

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

Questions About this Notice

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

² For purposes of this Financial Information Privacy Notice, "we" or "us" refers to health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc; OptumHealth Care Solutions, LLC; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holding, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. For a current list of entities subject to this notice go to www.uhc.com/privacy/entities-fn-v1

© 2024 United HealthCare Services, Inc.

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

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

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

□ **Information about our plan**. This includes, for example, information about the plan's financial condition.

☐ You have the	right to get information about the qualifications of the providers and
□Information abo Chapters 3 and	n our network and how we pay the providers in our network. but your coverage and the rules you must follow when using your coverage. 4 provide information regarding medical services. Chapters 5 and 6 provide ut Part D prescription drug coverage.
□Information about provides information drug is not cover	but why something is not covered and what you can do about it. Chapter 9 ation on asking for a written explanation on why a medical service or Part D red or if your coverage is restricted. Chapter 9 also provides information on ange a decision, also called an appeal.
Section 1.5	You have a right to participate with practitioners in making decisions about your health care. We must support your right to make decisions about your care and a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
You have the right nealth care	to know your treatment options and participate in decisions about your
•	o get full information from your doctors and other health care providers. Your ain your medical condition and your treatment choices in a way that you can
	ght to participate fully in decisions about your health care. To help you make doctors about what treatment is best for you, your rights include the following:
options that are covered by our	all of your choices. You have the right to be told about all of the treatment recommended for your condition, no matter what they cost or whether they are plan. It also includes being told about programs our plan offers to help ge their medications and use drugs safely.
You must be tol	the risks. You have the right to be told about any risks involved in your care. d in advance if any proposed medical care or treatment is part of a research always have the choice to refuse any experimental treatments.
the right to leave leave. You also	"no." You have the right to refuse any recommended treatment. This includes a hospital or other medical facility, even if your doctor advises you not to have the right to stop taking your medication. Of course, if you refuse p taking medication, you accept full responsibility for what happens to your

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

body as a result.

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

Section 1.6 You have a right to voice complaints or appeals about the organization or the care it provides. You have the right to make complaints and to ask us to reconsider decisions we have made
If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate state-specific agency, for example, your State Department of Health. See Chapter 2, Section 3 for contact information regarding your state-specific agency.
What if your instructions are not followed?
Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.
□ If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.
☐ The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.
□ Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.
□ Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
□ Get the form . You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service for assistance in locating an advanced directive form.
If you want to use an "advance directive" to give your instructions, here is what to do:
The legal documents that you can use to give your directions in advance of these situations are called advance directives . There are different types of advance directives and different names for them. Documents called living will and power of attorney for health care are examples of advance directives.
□ Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.
if you ever become unable to make decisions for yourself.
☐Fill out a written form to give someone the legal authority to make medical decisions for you

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

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

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

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

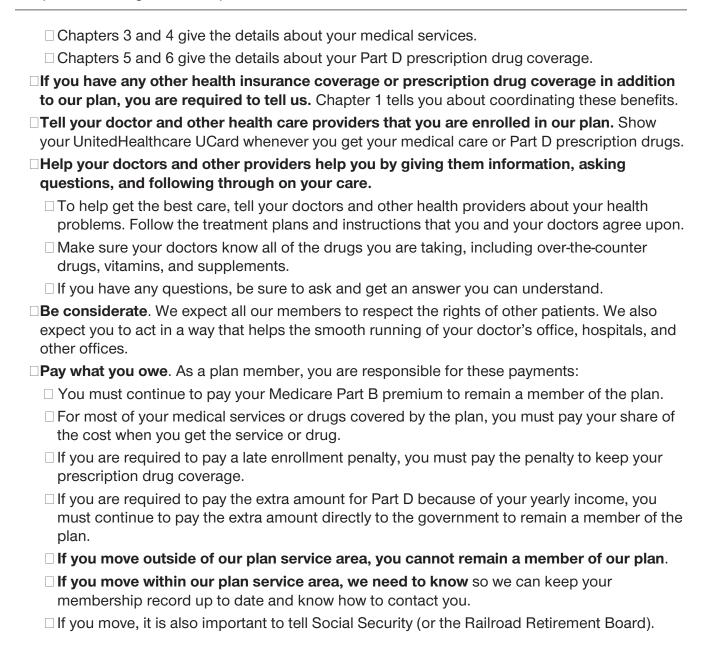
If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019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

Is it about someth	ning else?		
If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having: \[\textsup You can call Customer Service . \[\textsup You can call the SHIP. For details, go to Chapter 2, Section 3.			
			□ Or, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).
Section 1.8	You have a right to make recommendations regarding the organization's member rights and responsibilities policy. How to get more information about your rights		
There are several	places where you can get more information about your rights:		
☐ You can call (Customer Service.		
can also acces Additional Med	n on the quality program for your specific health plan, call Customer Service. You is this information online at uhc.com/medicare/resources.html. Open the dicare information and forms section and select Find information. Then select is and plan information and then Commitment to quality.		
□You can call th	e SHIP. For details, go to Chapter 2, Section 3.		
□You can conta	ct Medicare .		
Protections.	t the Medicare website to read or download the publication "Medicare Rights & " (The publication is available at: by/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf)		
□ Or, you can 1-877-486-2	call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 048).		
0 1 0	V		

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

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

☐Get familiar with your covered services and the rules you must follow to get these covered
services. Use this Evidence of Coverage to learn what is covered for you and the rules you
need to follow to get your covered services.



Chapter 9

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

Section 1 Introduction

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

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

□ For some problems, you need to use the **process for coverage decisions and appeals**.

□ For other problems, you need to use the **process for making complaints**; also called grievances.

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

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

Section 1.2 What about the legal terms?

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

\exists Uses simpler words in place of certain legal terms. For example, this chapter generally says
"making a complaint" rather than "filing a grievance," "coverage decision" rather than
"organization determination" or "coverage determination" or "at-risk determination" and
"independent review organization" instead of "Independent Review Entity."

☐ It also uses abbreviations as little as possible.

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

Section 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

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

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

176

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

Coverage decisions and appeals

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

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

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

Asking for coverage decisions prior to receiving benefits

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

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

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

Making an appeal

lf

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

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

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

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

☐You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.	
□See Section 5.4 of this chapter for more information about Level 2 appeals for medical care.	
□Part D appeals are discussed further in Section 6 of this chapter.	
If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue throug	jh
additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals	
processes).	

Section 4.2

How to get help when you are asking for a coverage decision or making an appeal Here are resources if you decide to ask for any kind of coverage decision or appeal a decision: ☐You can call us at Customer Service. □You can get free help from your State Health Insurance Assistance Program. Your doctor can make a request for you. If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) ☐ For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. ☐ For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal. □You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal. ☐ If you want a friend, relative, or another person to be your representative, call Customer Service and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at

☐ While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

person who you would like to act on your behalf. You must give us a copy of the signed form.

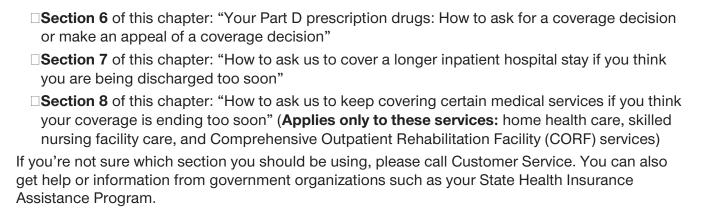
www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf .) The form gives that person permission to act on your behalf. It must be signed by you and by the

□You also have the right to hire a lawyer. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

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

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

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



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

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

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

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

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

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

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

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



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

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

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



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

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



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

For standard coverage decisions we use the standard deadlines.

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

- □ However, if you ask for more time, or if we need more information that may benefit you we can take up to 14 more calendar days if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- □ If you believe we should not take extra days, you can file a "fast complaint". We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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

- □ However, if you ask for more time, or if we need more information that may benefit you we can take up to 14 more calendar days. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- □ If you believe we should **not** take extra days, you can file a "fast complaint." (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- □ If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.



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

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

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

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

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



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

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

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



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

- □ If you are asking for a standard appeal, submit your standard appeal in writing. Chapter 2 has contact information.
- □ If you are asking for a fast appeal, make your appeal in writing or call us. Chapter 2 has contact information.
- □You must make your appeal request within 65 calendar days from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- □You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.



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

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

Deadlines for a "fast appeal"
□For fast appeals, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires us to.
☐ However, if you ask for more time, or if we need more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
☐ If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
□ If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
□ If our answer is no to part or all of what you requested, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.
Deadlines for a "standard appeal"
□For standard appeals, we must give you our answer within 30 calendar days after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
☐ However, if you ask for more time, or if we need more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
If you believe we should not take extra days, you can file a "fast complaint". When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 1 of this chapter for information on complaints.)
☐ If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
□ If our answer is yes to part or all of what you requested, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or within 7 calendar days if your request is for a Medicare Part B prescription drug.
☐ If our plan says no to part or all of your appeal, we will automatically send your appeal to the

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

independent review organization for a Level 2 appeal.

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

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

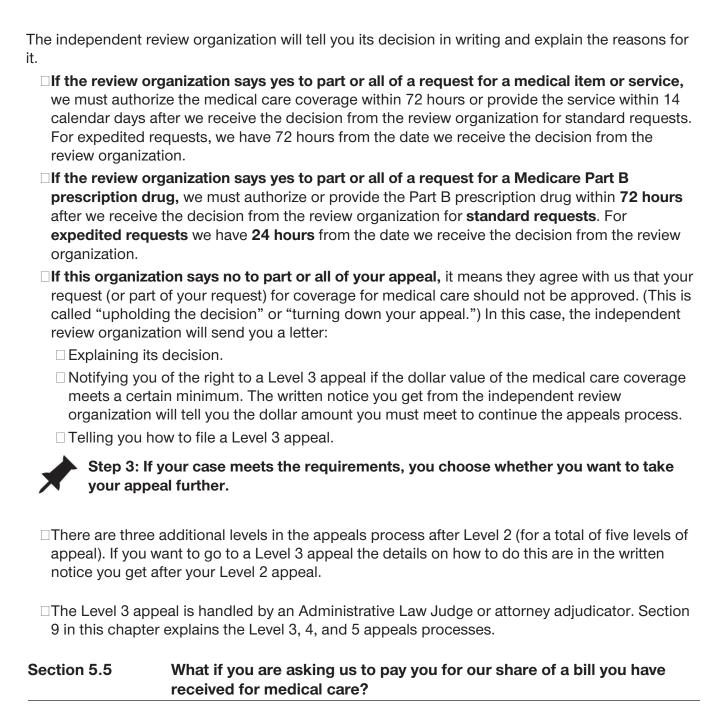


Step 1: The independent review organization reviews your appeal.

□We will send the information about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file.
☐You have a right to give the independent review organization additional information to support your appeal.
☐ Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2
☐ For the "fast appeal" the review organization must give you an answer to your Level 2 appeal within 72 hours of when it receives your appeal.
□ However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2
□For a "standard appeal" if your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal within 30 calendar days of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal within 7 calendar days of when it receives your appeal.
□ However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, it can take up to 14 more calendar days . The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.



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



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

Asking for reimbursement is asking for a coverage decision from us

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

- □ If we say yes to your request: If the medical care is covered and you followed all the rules, we will send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- □ If we say no to your request: If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

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

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

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

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

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time. We also use the term "drug list" instead of "List of Covered Drugs" or "Formulary."

□ If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.

187

□ If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term An initial coverage decision about your Part D drugs is called a "coverage determination."	Legal Term	
---	------------	--

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

□Asking to cover a Part D o	drug that is not on	the plan's List of	Covered Drugs.	Ask for an
exception. Section 6.2				

- □ Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- □ Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- □ Pay for a prescription drug you already bought. Ask us to pay you back. Section 6.4

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

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

Section 6.2 What is an exception?

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

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

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

- 1.Covering a Part D drug for you that is not on our Drug List. If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to all of our drugs. For insulin drugs that are not on the Drug List, you will pay no more than \$35 for a 1-month supply or \$105 for a 3-month supply. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
- **2.Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our **Drug List**.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

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

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Term	A "fast coverage decision" is called an "expedited coverage
	determination."



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

"Standard coverage decisions" are made within 72 hours after we receive your doctor's statement. "Fast coverage decisions" are made within 24 hours after we receive your doctor's statement.
If your health requires it, ask us to give you a "fast coverage decision." To get a fast coverage decision, you must meet two requirements:
You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically give you a fast coverage decision.
If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:
Explains that we will use the standard deadlines.

☐ Explains if your doctor or other prescriber asks for the fast coverage decision, we will

☐ Tells you how you can file a "fast complaint" about our decision to give you a standard

automatically give you a fast coverage decision.

complaint within 24 hours of receipt.



Step 2: Request a "standard coverage decision" or a "fast coverage decision."

coverage decision instead of the fast coverage decision you requested. We will answer your

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website (MyUHCMedicare.com). Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

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

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



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

Deadlines for a "fast" coverage decision □We must generally give you our answer within 24 hours after we receive your request. ☐ For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to. ☐ If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. □ If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request. □ If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said **no**. We will also tell you how you can appeal. Deadlines for a "standard" coverage decision about a drug you have not yet received We must generally give you our answer within 72 hours after we receive your request. ☐ For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to. ☐ If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. □ If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request. □ If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal. Deadlines for a "standard" coverage decision about payment for a drug you have already bought We must give you our answer within 14 calendar days after we receive your request. □ If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. □ If our answer is yes to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request. □ If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.



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

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

Section 6.5 Step-by-step: How to make a Level 1 appeal

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



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

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

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



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

□F	or stand	ard a	ippeals, s	submit	a written	request.	Chapter	2 ha	s contact	infor	mation.
----	----------	-------	------------	--------	-----------	----------	---------	------	-----------	-------	---------

□ For fast appeals either submit your appeal in writing or call us at 1-800-711-0646. Chapter 2 has contact information.

- □ We must accept any written request, including a request submitted on the CMS Model Redetermination Request Form, which is available on our website (MyUHCMedicare.com). Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- □You must make your appeal request within 65 calendar days from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include

a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

☐ You can ask for a copy of the information in your appeal and add more information. You and your doctor may add more information to support your appeal.



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

□When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.
 Deadlines for a "fast appeal"
 □For fast appeals, we must give you our answer within 72 hours after we receive your appeal.

- We will give you our answer sooner if your health requires us to.

 ☐ If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeals process.
- □ If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard" appeal for a drug you have not yet received

- □ For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
 - ☐ If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- □ If our answer is yes to part or all of what you requested, we must provide the coverage as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.
- □ If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how you can appeal our decision.

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

- □We must give you our answer within 14 calendar days after we receive your request.
 - ☐ If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- □ If our answer is yes to part or all of what you requested, we are also required to make payment to you within 30 calendar days after we receive your request.

□ If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.



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

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

Section 6.6 Step-by-step: How to make a Level 2 appeal

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

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



Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

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

□We will send the information about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file.

□You have a right to give the independent review organization additional information to support your appeal.



Step 2: The independent review organization reviews your appeal.

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

Deadlines for "fast" appeal

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

Deadlines for "standard" appeal

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



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

For "fast" appeals

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

For "standard" appeals

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

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called "upholding the decision." It is also called "turning down your appeal.") In this case, the independent review organization will send you a letter:

□Explaining its decision.
□Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
☐ Telling you the dollar value that must be in dispute to continue with the appeals process.



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

your app	eal further.
□There are three appeal).	additional levels in the appeals process after Level 2 (for a total of five levels of
	o on to a Level 3 appeal the details on how to do this are in the written notice our Level 2 appeal decision.
	peal is handled by an Administrative Law Judge or attorney adjudicator. Section r tells more about Levels 3, 4, and 5 of the appeals process.
Section 7	How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon
•	itted to a hospital, you have the right to get all of your covered hospital services to diagnose and treat your illness or injury.
• •	ed hospital stay, your doctor and the hospital staff will be working with you to when you will leave the hospital. They will help arrange for care you may need
☐The day you lea	ave the hospital is called your "discharge date."
□When your disc	charge date is decided, your doctor or the hospital staff will tell you.
•	are being asked to leave the hospital too soon, you can ask for a longer hospital equest will be considered.
Section 7.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights
An Important Mes of this notice. If you or nurse), ask any h	r days of being admitted to the hospital, you will be given a written notice called sage from Medicare about Your Rights. Everyone with Medicare gets a copy do not get the notice from someone at the hospital (for example, a caseworker nospital employee for it. If you need help, please call Customer Service or 1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).
1. Read this noti	ce carefully and ask questions if you don't understand it. It tells you:
ordered by y	receive Medicare-covered services during and after your hospital stay, as our doctor. This includes the right to know what these services are, who will pay d where you can get them.

☐ Your right to be involved in any decisions about your hospital stay.

☐ Where to report any concerns you have about the quality of your hospital care.

☐ Your right to request an immediate review of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delain your discharge date so that we will cover your hospital care for a longer time.
2. You will be asked to sign the written notice to show that you received it and understand your rights.
\square You or someone who is acting on your behalf will be asked to sign the notice.
Signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date. Signing the notice does not mean you are agreeing on a discharge date.
3. Keep your copy of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
If you sign the notice more than two calendar days before your discharge date, you will get another copy before you are scheduled to be discharged.
☐ To look at a copy of this notice in advance, you can call Customer Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.
Section 7.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date
If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:
□Follow the process.
□Meet the deadlines.
□ Ask for help if you need it. If you have questions or need help at any time, please call Customer Service. Or, call your State Health Insurance Assistance Program, a government

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

organization that provides personalized assistance.

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



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

How can you contact this organization?

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

Act quickly:

□To make your appeal, you must contact the Quality Improvement Organization before you le	eave
the hospital and no later than midnight the day of your discharge.	

☐ If you meet this deadline, you may stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.

☐ If you do **not** meet this deadline, contact us. If you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.

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

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.



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

\square Health professionals at the Quality Improvement Organization (we will call them "the reviewers"
will ask you (or your representative) why you believe coverage for the services should continue.
You don't have to prepare anything in writing, but you may do so if you wish.
Tou don't have to prepare anything in writing, but you may do so it you wish.

☐ The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

□By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.



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

What happens if the answer is yes?

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

What happens if the answer is no?

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



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

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

Section 7.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

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



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

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



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

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



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

If the review organization says yes:

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

If the review organization says no:

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



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

- □There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- □ The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

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

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

Section 8.2 We will tell you in advance when your coverage will be ending

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

Section 8.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

Follow the process.

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

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

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



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

How can you contact this organization?

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

Act quickly:

☐You must contact the Quality Improvement Organization to start your appeal by ne	oon of t	he day
before the effective date on the Notice of Medicare Non-Coverage.		

□ If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.



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

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

What happens during this review?

☐ Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or
your representative, why you believe coverage for the services should continue. You don't have
to prepare anything in writing, but you may do so if you wish.
□The review organization will also look at your medical information, talk with your doctor, and
review the information that our plan has given to them.

\square By the end of the day the reviewers tell us of your appeal, you will get the Detailed Explanati	or
of Non-Coverage from us that explains in detail our reasons for ending our coverage for you	r
services.	



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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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



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

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

Section 8.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

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



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

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



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

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



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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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



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

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

□ The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 9 Taking your appeal to Level 3 and beyond

Section 9.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

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

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

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

Level 3 appeal: An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.
If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
☐ If we decide not to appeal, we must authorize or provide you with the medical care within 6 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
☐ If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
□ If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appear process may or may not be over.
If you decide to accept this decision that turns down your appeal, the appeals process is over.
☐ If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.
Level 4 appeal: The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.
If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process may or may not be over. Unlike a decision at Level 2 we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
☐ If we decide not to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
$\hfill \square$ If we decide to appeal the decision, we will let you know in writing.
☐ If the answer is no or if the Council denies the review request, the appeals process may of may not be over.

ept this decision that turns down your appeal, the appeals process is
accept the decision, you may be able to continue to the next level of the Council says no to your appeal, the notice you get will tell you whether go on to a Level 5 appeal and how to continue with a Level 5 appeal.
A judge at the Federal District Court will review your appeal.
of the information and decide yes or no to your request. This is a final nore appeal levels after the Federal District Court.
eal Levels 3, 4, and 5 for Part D Drug Requests
priate for you if you have made a Level 1 appeal and a Level 2 appeal, ave been turned down.
have appealed meets a certain dollar amount, you may be able to go on al. If the dollar amount is less, you cannot appeal any further. The we to your Level 2 appeal will explain who to contact and what to do to
olve appeals, the last three levels of appeal work in much the same way. view of your appeal at each of these levels.
An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.
ne appeals process is over. We must authorize or provide the drug roved by the Administrative Law Judge or attorney adjudicator within 72 spedited appeals) or make payment no later than 30 calendar days cision.
e appeals process may or may not be over.
ept this decision that turns down your appeal, the appeals process is
accept the decision, you can continue to the next level of the review you get will tell you what to do for a Level 4 appeal.
The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal

or make payment no later than 30 calendar days after we receive the decision.

☐ If the answer is no, the appeals process may or may not be over. ☐ If you decide to accept this decision that turns down your appeal, the appeals process is over.
☐ If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.
Level 5 appeal: A judge at the Federal District Court will review your appeal.
□ A judge will review all of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

Section 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	☐Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	☐ Has someone been rude or disrespectful to you? ☐ Are you unhappy with our Customer Service? ☐ Do you feel you are being encouraged to leave the plan?
Waiting times	□Are you having trouble getting an appointment, or waiting too long to get it? □Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Customer Service or other staff at our plan?

Complaint	Example
	☐ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	□Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you	□Did we fail to give you a required notice?
get from us	☐s our written information hard to understand?
Timeliness (These types of complaints are all	If you have asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:
related to the timeliness of our	☐You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint.
actions related to coverage decisions and	☐You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint.
appeals)	You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint.
	☐You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

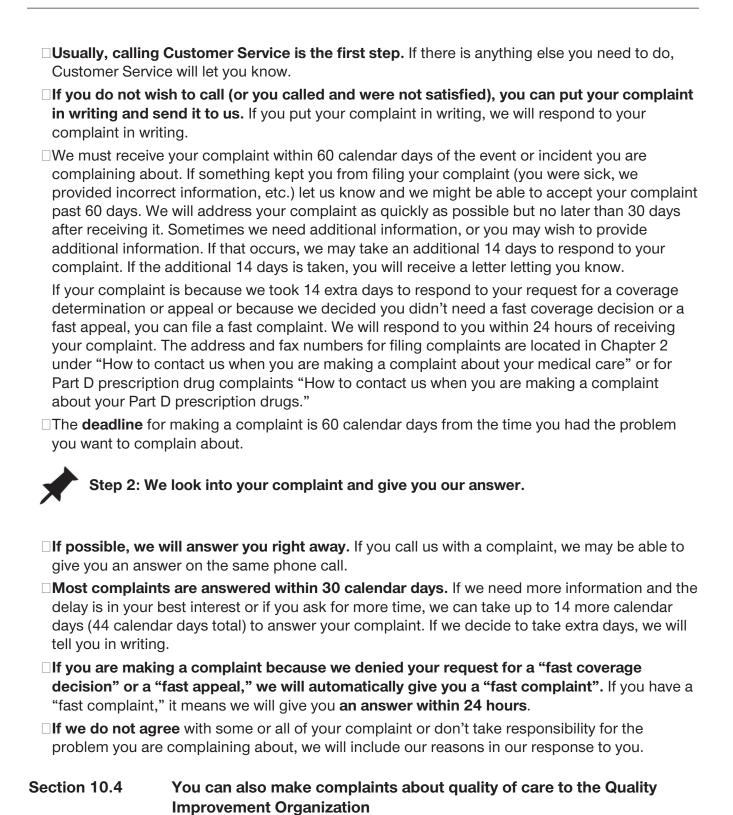
Section 10.2 How to make a complaint

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

Section 10.3 Step-by-step: Making a complaint



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



2025 Evidence of Coverage for UHC Nursing Home Plan EX-F003 (PPO I-SNP)
Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals,
complaints)

209

□You can make	your complaint directly to the Quality Improvement Organization.
experts paid b	provement Organization is a group of practicing doctors and other health care y the Federal government to check and improve the care given to Medicare ter 2 has contact information.
	Or
□You can make same time.	e your complaint to both the Quality Improvement Organization and us at the
Section 10.5	You can also tell Medicare about your complaint

You can submit a complaint about UHC Nursing Home Plan EX-F003 (PPO I-SNP) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Chapter 10

Ending your membership in the plan

Section 1 Introduction to ending your membership in our plan

Ending your membeown choice):	ership in the plan may be voluntary (your own choice) or involuntary (not your
•	our plan because you have decided that you want to leave. Sections 2 and 3 tion on ending your membership voluntarily.
	mited situations where you do not choose to leave, but we are required to end ip. Section 5 tells you about situations when we must end your membership.
•	ur plan, our plan must continue to provide your medical care and prescription continue to pay your cost share until your membership ends.
Section 2	When can you end your membership in our plan?
Section 2.1	You can end your membership at any time
You can end your m	nembership in our plan at any time.
•	e in a nursing home, you can end your membership in UHC Nursing Home Plan SNP) at any time.
\square If you decide to	change to a new plan, you can choose any of the following types of plans:
□ Another Medica	re health plan, with or without prescription drug coverage.
□Original Medica	re with a separate Medicare prescription drug plan.
□- or - Original Me	edicare without a separate Medicare prescription drug plan.
☐ If you choose of automatic	this option, Medicare may enroll you in a drug plan, unless you have opted out enrollment.
prescription d	isenroll from Medicare prescription drug coverage and go without creditable rug coverage for 63 or more days in a row, you may have to pay a Part D late nalty if you join a Medicare drug plan later.
□Your membersh your plan is rece	ip will usually end on the first day of the month after your request to change eived.
•	drug management program, you may not be able to change plans. Chapter 5, more about drug management programs.
Section 2.2	Where can you get more information about when you can end your membership?
	stions about ending your membership you can:
□ Call Customer	
	ation in the Medicare & You 2025 handbook.
□Contact Medica 1-877-486-2048	are at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY).

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

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

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

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

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

our medical terms, services and prescription drugs through our plan.
□Continue to use our network providers to receive medical care.
□Continue to use our network pharmacies or mail order to get your prescriptions filled.
☐ If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

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

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

We must end your membership in the plan if any of the following happen:	
□If you no longer have Medicare Part A and Part B.	
□If you move out of our service area.	
☐ If you are away from our service area for more than 6 months.	
If you move or take a long trip, call Customer Service to find out if the plac or traveling to is in our plan's area.	e you are moving
\square You do not meet the plan's special eligibility requirements.	
If you no longer reside in a network skilled nursing facility or no longer res assisted living facility whereby you required an institutional level of care. We thirty (30) days' notice before you are disenrolled, unless you have chosen disenroll.	Ve will provide you
□If you become incarcerated (go to prison).	
\Box If you are no longer a United States citizen or lawfully present in the United S	States.
☐ If you lie or withhold information about other insurance you have that provide drug coverage.	es prescription
☐ If you intentionally give us incorrect information when you are enrolling in our information affects your eligibility for our plan. (We cannot make you leave or reason unless we get permission from Medicare first.)	•
☐ If you continuously behave in a way that is disruptive and makes it difficult fo medical care for you and other members of our plan. (We cannot make you I this reason unless we get permission from Medicare first.)	•
☐ If you let someone else use your UnitedHealthcare UCard to get medical card make you leave our plan for this reason unless we get permission from Medi	,
If we end your membership because of this reason, Medicare may have you investigated by the Inspector General.	our case
☐ If you are required to pay the extra Part D amount because of your income an it, Medicare will disenroll you from our plan and you will lose prescription dru	

Where can you get more information?

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

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

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

What should you do if this happens?

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

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

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

Chapter 11 Legal notices

Section 1 Notice about governing law

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

Section 2 Notice about non-discrimination

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

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

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

Section 3 Notice about Medicare Secondary Payer subrogation rights

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

Section 4 Third party liability and subrogation

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

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

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

Section 5 Member liability

□Post-stabilization services

In the event we fail to reimburse provider's charges for covered services, you will not be liable for any sums owed by us. Neither the plan nor Medicare will pay for non-covered services except for the following eligible expenses:
□Emergency services
□Urgently needed services
□Out-of-area and routine travel dialysis (must be received in a Medicare Certified Dialysis Facility within the United States)

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

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

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

□Safe and effective;
□Not experimental or investigational; and
□ Appropriate, including the duration and frequency that is considered appropriate for the
service, in terms of whether it is:

- 1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
- 2. Furnished in a setting appropriate to the patient's medical needs and condition;
- 3. Ordered and furnished by qualified personnel;
- 4. One that meets, but does not exceed, the patient's medical need; and
- 5. At least as beneficial as an existing and available medically appropriate alternative.

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

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

Section 8 Acts beyond our control

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

Section 9 Contracting medical providers and network hospitals are independent contractors

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

Section 10 Technology assessment

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

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

Section 11 Member statements

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

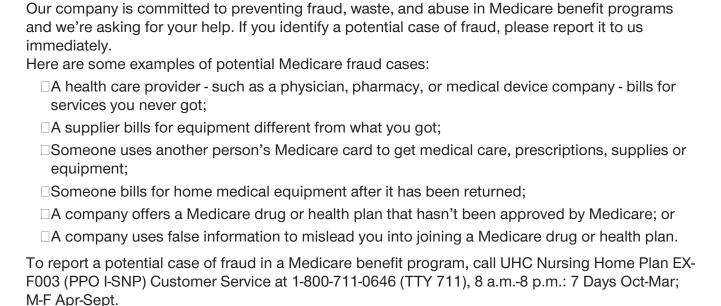
Section 12 Information upon request

As a plan member, you have the right to request information on the following:
☐General coverage and comparative plan information
☐Utilization control procedures
□Quality improvement programs
□Statistical data on grievances and appeals
☐The financial condition of UnitedHealthcare Insurance Company or one of its affiliates

2025 Enrollee Fraud & Abuse Communication

2025 Enrollee Fraud & Abuse Communication **How you can fight healthcare fraud**

Section 13



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

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

Section 14 Commitment of Coverage Decisions

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

Chapter 12

Definitions of important words

Chapter 12

Definitions of important words

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

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

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

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of UHC Nursing Home Plan EX-F003 (PPO I-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.

Benefit period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also Original Biological Product and Biosimilar).

Biosimilar – A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (See Interchangeable Biosimilar).

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,000 for Medicare-covered Part D drugs during the covered year. During this payment stage, you pay nothing for your Medicare-covered Part D drugs.

Centers for Medicare & Medicaid Services (CMS) - The Federal agency that administers

Medicare.

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

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

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles. Coinsurance for in-network services is based upon contractually negotiated rates (when available for the specific covered service to which the coinsurance applies) or Medicare Allowable Cost, depending on our contractual arrangements for the service.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount.

Compendia – Medicare-recognized reference books for drug information and medically accepted indications for Part D coverage.

Complaint – The formal name for making a complaint is filing a grievance. The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example \$10), rather than a percentage.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under

your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this document.

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

Covered Services – The term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is \$1 per day.

Daily Cost Share applies only if the drug is in the form of a solid oral dose (e.g., tablet or capsule) when dispensed for less than a one-month supply under applicable law. The Daily Cost Share requirements do not apply to either of the following:

- 1. Solid oral doses of antibiotics.
- 2. Solid oral doses that are dispensed in their original container or are usually dispensed in their original packaging to assist patients with compliance.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons.

Emergency - A medical emergency is when you, or any other prudent layperson with an average

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

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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

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

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Chapter 4, Section 2.1 under the heading "Home health agency care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people

who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day/7 days a week.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from in-network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

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

Institutional Equivalent Special Needs Plan (SNP) - A plan that enrolls eligible individuals living

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

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) - See "Extra Help."

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

Maximum Charge (Limiting Charge) – In the Original Medicare plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don't accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

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

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

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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

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

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

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

cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Allowable Cost – The maximum price of a service for reimbursement purposes under Original Medicare.

Medicare Assignment – In Original Medicare, a doctor or supplier "accepts assignment" when he or she agrees to accept the Medicare-approved amount as full payment for covered services. For covered out-of-network services, it can save you money if your doctor or supplier accepts assignment. If a doctor or supplier accepts assignment, your cost-sharing is limited to your copayment or coinsurance amount for the covered service.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 1, Section 3.2)

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

Network Provider – "Provider" is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. "Network providers" have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Organization Determination - A decision our plan makes about whether items or services are

covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

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

Out-of-pocket costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service.

Part C - see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

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 members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member 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.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – For medical services it means a process where your PCP or treating provider must receive approval in advance before certain medical services will be provided or payable. For certain drugs it means a process where you or your provider must receive approval in advance before certain drugs will be provided or payable. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria is posted on our website. In the network portion of a PPO, some in-network medical services are covered only if your PCP or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your costs-sharing responsibility is.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

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

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

Real-Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Retail Walk-In Clinic – A provider location that generally does not require appointments and may be a standalone location or located in a retail store, supermarket or pharmacy. Walk-In Clinic Services are subject to the same cost-sharing as Urgent Care Centers. (See the Benefit Chart in Chapter 4)

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or

intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

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

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

UHC Nursing Home Plan EX-F003 (PPO I-SNP) Customer Service:



Call **1-800-711-0646**

Calls to this number are free. 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept. Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**

Calls to this number are free. 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

 \subseteq

Write: P.O. Box 30770 Salt Lake City, UT 84130-0770

MyUHCMedicare.com

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. You can call the SHIP in your state at the number listed in Chapter 2 Section 3 of the Evidence of Coverage.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.