Enrollee Handbook 2026

UHC Dual Choice DC-Y2 (PPO D-SNP)

MyUHC.com/CommunityPlan

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

United Healthcare®

Y0066_EOC_H2406_053_000_2026_C

January 1–December 31, 2026

UHC Dual Choice DC-Y2 (PPO D-SNP) *Enrollee Handbook* for 2026

Your Medicare & District Medicaid Health and Drug Coverage under UHC Dual Choice DC-Y2 (PPO D-SNP)

Thank you for choosing UnitedHealthcare Community Plan. UnitedHealthcare Community Plan operates the District Dual Choice Program. UHC Dual Choice DC-Y2 (PPO D-SNP) program provides both Medicaid and Medicare covered benefits.

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

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan. We are required to cover all Part A and Part B services. However, cost-sharing and provider access in this plan differ from Original Medicare.

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

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

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

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

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

- **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-sharing and are also eligible for full Medicaid benefits. Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance, and copayment amounts for Medicare covered services. You pay nothing, except for Part D prescription drug copays (if applicable).

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

- **Full Benefits Dual Eligible (FBDE)**: Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You're eligible for full Medicaid benefits. Your cost share is 0% when the service is covered by both Medicare and Medicaid.

Enrollee Handbook Introduction

This *Enrollee Handbook*, otherwise known as the **Evidence of Coverage**, tells you about your coverage under our plan through December 31, 2026. It explains health services and drug coverage. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *Enrollee Handbook*.

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

When this *Enrollee Handbook* says "we", "us", "our", or "our plan", it means UHC Dual Choice DC-Y2 (PPO D-SNP).

This document is available for free in Spanish and Amharic.

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

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

You can call Enrollee Services and ask us to make a note in our system that you would like materials in your preferred language, large print, braille, or audio now and in the future. This is called a "standing order". You can also make changes to your standing order at any time by calling Enrollee Services.

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

Notice of nondiscrimination

UnitedHealthcare complies with applicable Federal and District of Columbia civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of any of the following:

- Race or ancestry
- Color
- Creed
- Religion
- Age
- National origin
- Language
- Marital status
- Sex (including sexual orientation and gender identity)
- Medical condition or disability (including physical or mental impairment)
- Pregnancy
- Family responsibilities
- Source of income
- Place of residence
- Political affiliation
- Personal appearance

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, please call Enrollee Services at **1-866-242-7726,** TTY **711,** between 8:00 a.m.–5:30 p.m. ET, Monday–Friday, months April–September; 8:00 a.m.–8:00 p.m. ET, 7 days a week, months October–March.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

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

UHC_Civil_Rights@uhc.com

Optum Civil Rights Coordinator
1 Optum Circle
Eden Prairie, MN 55344

Optum_Civil_Rights@Optum.com

If you need help filing a complaint, call the toll-free number on your enrollee identification card (TTY **711**). If you need any other assistance, please contact the Office of Health Care Ombudsman at 202-724-7491.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

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

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

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

Complaint forms are available at: **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at: **https://www.uhc.com/nondiscrimination-med**
https://www.optum.com/en/language-assistance-nondiscrimination.html

Notice of availability
of language assistance services and alternate formats

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

እንግሊዘኛ የማይናገሩ እና/ወይም የማያነቡ ከሆነ፣ እባክዎን በ1-866-242-7726፣ TTY 711፣ ከጠዋቱ 8፡00 - ከሰዓት 5፡30 EST፣ ሰኞ - አርብ፣ ኤፕሪል - ሴፕቴምበር ወራት፤ ጠዋት 8:00 - ከሰዓት 8:00 EST፣ በሳምንት 7 ቀናት፣ ከአክቶበር - ማርች ወራት ይደውሉ። ተወካይ ያነጋግርዎታል።

إذا كنت لا تتحدث و/أو لا تقرأ اللغة الإنجليزية، يُرجى الاتصال على الرقم 1-866-242-7726 (TTY 711)، بين الساعة 8:00 صباحًا و 5:30 مساءً بالتوقيت الشرقي القياسي، من الاثنين إلى الجمعة، خلال أشهر أبريل حتى سبتمبر؛ ومن الساعة 8:00 صباحًا حتى 8:00 مساءً بالتوقيت الشرقي القياسي، طوال أيام الأسبوع، خلال أشهر أكتوبر حتى مارس. وسيساعدك أحد الممثلين.

အကယ်၍ သင်သည် အင်္ဂလိပ်လိုမပြောတတ် နှင့်/သို့မဟုတ် မဖတ်တတ်ပါက ကျေးဇူးပြု၍ 1-866-242-7726၊ TTY 711 ထံသို့ ဖုန်းခေါ်ဆိုပါ။ ကိုယ်စားလှယ်တစ်ဦးက သင့်ကို ကူညီပေးပါလိမ့်မည်။

如果您不能说和 / 或读英语，请致电 1-866-242-7726，听力语言残障服务专线 (TTY) 711，4 月至 9 月周一至周五，东部标准时间 (EST) 上午 8:00 至下午 5:30；10 月至 3 月每周 7 天，东部标准时间 (EST) 上午 8:00 至晚上 8:00。会有一位代表为您提供协助。

如果您不能說和 / 或讀英語，請致電 1-866-242-7726，聽力語言殘障服務專線 (TTY) 711，4 月至 9 月週一至週五，東部標準時間 (EST) 上午 8:00 至下午 5:30；10 月至 3 月每週 7 天，東部標準時間 (EST) 上午 8:00 至晚上 8:00。會有一位代表爲您提供協助。

اگر به زبان انگلیسی صحبت نمی‌کنید و/یا نمی‌توانید بخوانید، لطفاً با شماره 1-866-242-7726 (TTY 711) تماس بگیرید. ساعات پاسخگویی از دوشنبه تا جمعه، بین ساعات 8:00 AM تا 5:30 PM به وقت EST در ماه‌های آوریل تا سپتامبر، و همه روزه بین ساعات 8:00 AM تا 8:00 PM به وقت EST در ماه‌های اکتبر تا مارس می‌باشد. یک نماینده به شما کمک خواهد کرد.

Si vous ne parlez pas et/ou ne lisez pas l'anglais, veuillez appeler le 1-866-242-7726, TTY 711, entre 8:00am et 5:30pm heure de l’Est, du lundi au vendredi, d'avril à septembre ; et entre 8:00am et 8:00pm heure de l’Est, 7 jours sur 7, d'octobre à mars. Un représentant vous aidera.

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

यदि आप अंग्रेज़ी नहीं बोल सकते और/या पढ़ नहीं सकते, तो कृपया 1-866-242-7726, TTY 711 पर कॉल करें। अप्रैल से सितंबर तक सोमवार से शुक्रवार, सुबह 8:00 बजे से शाम 5:30 बजे (EST) तक, और अक्टूबर से मार्च तक सप्ताह के सातों दिन, सुबह 8:00 बजे से रात 8:00 बजे (EST) तक कॉल कर सकते हैं। एक प्रतिनिधि आपकी सहायता करेगा।

Yog tias koj tsis paub hais thiab/los sis nyeem tsis tau ntawv Askiv, thov hu rau 1-866-242-7726, TTY 711, thaum 8:00 teev sawv ntxov – 5:30 teev tsaus ntuj lub sij hawm EST, hnub Monday – hnub Friday, lub Plaub Hlis – Cuaj Hli; 8:00 teev sawv ntxov - 8:00 teev tsaus ntuj lub sij hawm EST, 7 hnub hauv ib lub lim tiam, lub Kaum Hli - Lub Peb Hlis. Ib tug neeg sawv cev yuav los pab koj.

Se non parla o legge l’inglese, chiami il numero 1-866-242-7726 (TTY 711), attivo dal lunedì al venerdì, dalle 8:00 alle 17:30 EST, nei mesi da aprile a settembre e attivo tutti i giorni, dalle 8:00 alle 20:00 EST, nei mesi da ottobre a marzo. Un nostro consulente le fornirà assistenza.

英語を話したり読んだりできない場合は、1-866-242-7726、TTY 711 までお電話ください。受付時間：4 月～9 月は月曜日～金曜日、東部標準時午前 8 時～午後 5 時 30 分。10 月～3 月は毎日、東部標準時午前 8 時～午後 8 時です。担当者がお手伝いいたします。

영어를 말하거나 읽을 수 없는 경우, 1-866-242-7726, TTY 711 번으로 4 월-9 월, 월요일-금요일, 오전 8 시-오후 5 시 30 분(동부표준시), 10 월-3 월, 주 7 일, 오전 8 시-오후 8 시(동부표준시) 사이에 전화하십시오. 담당자가 도와드릴 것입니다.

Jeśli nie mówi i/lub nie czyta Pan/Pani w języku angielskim, prosimy zadzwonić pod numer 1-866-242-7726, TTY 711, w godzinach od 8:00 rano do 5:30 wieczorem czasu EST, od poniedziałku do piątku, od kwietnia do września; w godzinach od 8:00 rano do 8:00 wieczorem czasu EST, 7 dni w tygodniu, od października do marca. Przedstawiciel udzieli Panu/Pani pomocy.

Se você não fala ou lê inglês, ligue para 1-866-242-7726, TTY 711, entre 8:00 a.m. e 5:30 p.m. EST, de segunda a sexta-feira entre os meses de abril e setembro, e entre 8:00 a.m. e 8:00 p.m. EST, 7 dias por semana entre os meses de outubro e março. Um representante auxiliará você.

ਜੇਕਰ ਤੁਸੀਂ ਅੰਗਰੇਜ਼ੀ ਬੋਲ ਨਹੀਂ ਸਕਦੇ ਅਤੇ/ਜਾਂ ਪੜ੍ਹ ਨਹੀਂ ਸਕਦੇ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 1-866-242-7726, TTY 711 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪ੍ਰੈਲ ਤੋਂ ਸਤੰਬਰ ਤੱਕ ਸੋਮਵਾਰ ਤੋਂ ਸ਼ੁੱਕਰਵਾਰ, ਸਵੇਰੇ 8:00 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 5:30 ਵਜੇ (EST) ਤੱਕ, ਅਤੇ ਅਕਤੂਬਰ ਤੋਂ ਮਾਰਚ ਤੱਕ ਹਫਤੇ ਦੇ ਸੱਤੋਂ ਦਿਨ, ਸਵੇਰੇ 8:00 ਵਜੇ ਤੋਂ ਰਾਤ 8:00 ਵਜੇ (EST) ਤੱਕ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ। ਇੱਕ ਨੁਮਾਇੰਦਾ ਤੁਹਾਡੀ ਮਦਦ ਕਰੇਗਾ।

Если вы не говорите и/или не читаете по–английски, обращайтесь по телефону 1-866-242-7726 (линия TTY: 711) в соответствии со следующим графиком работы: с 8:00am до 5:30pm по восточному времени (EST) с понедельника по пятницу в период с с апреля по сентябрь; с 8:00am до 8:00pm по восточному времени (EST) ежедневно в период с октября по март. Представитель компании окажет вам помощь.

Haddii aadan ku hadlin iyo/ama aadan akhrin Af-Ingirisiga, fadlan wac 1-866-242-7726, TTY 711, inta u dhaxeysa 8:00am – 5:30pm EST, Isniin – Jimce, bilaha Abriil – Setenbar; 8:00am – 8:00pm EST, 7 maalmood isbuucii, bilaha Oktoobar – Maarso. Wakiil ayaa ku caawin doona.

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

Kung hindi ka makapagsalita at/o makapagbasa ng Ingles, pakitawagan ang 1-866-242-7726, TTY 711, 8:00am – 5:30pm EST, Lunes – Biyernes, mga buwan ng Abril – Setiembre; 8:00am – 8:00pm EST, 7 araw kada linggo, mga buwan ng Oktubre – Marso. May representative na tutulong sa iyo.

Nếu quý vị không nói và/hoặc đọc tiếng Anh, vui lòng gọi số 1-866-242-7726, TTY 711, 8:00 sáng – 5:30 chiều theo giờ EST, thứ Hai đến thứ Sáu, trong giai đoạn từ tháng 4 đến tháng 9; 8:00 sáng – 8:00 tối theo giờ EST, tất cả các ngày trong tuần, trong giai đoạn từ tháng 10 đến tháng 3. Một nhân viên đại diện sẽ hỗ trợ quý vị.

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Disclaimers

UHC Dual Choice DC-Y2 (PPO D-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the District Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare and with District Medicaid.

Our formulary, pharmacy network, and provider network can change at any time. You'll get notice about any chances that can affect you at least 30 days in advance.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2027.

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

Chapter 1: Getting started as an enrollee

Introduction

This chapter includes information about UHC Dual Choice DC-Y2 (PPO D-SNP), a health plan that coordinates all of your Medicare and DC Medicaid services, and your enrollment in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Enrollee Handbook*.

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A. Welcome to our plan

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

B. Information about Medicare and DC Medicaid

B1. Medicare

Medicare is the federal health insurance program for:

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

B2. DC Medicaid

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

Each state or the District decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

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

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

- we choose to offer the plan, **and**
- Medicare and the District allow us to continue to offer this plan.

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

C. Advantages of our plan

You'll now get all your covered Medicare and DC Medicaid services from our plan, including prescription drugs. **You don't pay extra to join this health plan.**

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

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

D. Our plan's service area

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

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of your *Enrollee Handbook* for more information about the effects of moving out of our service area.

If you plan to move out of the service area, you can't remain an enrollee of this plan. Please contact Enrollee Services number at **1-866-242-7726**, TTY **711**, to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that's available in your new location. It's also important that you call Social Security if you move or change your mailing address.

E. What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**

- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for DC Medicaid, **and**
- you're at least 21 years old, **and**
- Are eligible for both Medicare and full Medicaid benefits (QMB+ or FBDE). Our plan is designed to meet the needs of people who receive Medicaid benefits. (Medicaid is a joint Federal and District government program that helps with medical costs for certain people with limited incomes and resources) **and**
- Meet the requirement for the following Medicaid Categories:
  - Elderly and Persons with Physical Disabilities Waiver Program (EPD Waiver)
  - Nursing Facility Resident

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

Call Enrollee Services for more information.

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

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

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

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

We'll send you more information about this HRA.

G. Your care team and care plan

G1. Care team

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

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

G2. Care plan

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

Your care plan includes:

- your health care goals, **and**
- a timeline for getting the services you need.

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

H. Summary of important costs

Your costs may include the following:

- Plan premium (**Section H1**)
- Monthly Medicare Part B Premium (**Section H2**)
- Part D Late Enrollment Penalty (**Section H3**)

In some situations, your plan premium could be less.

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

If you **already enrolled** and get help from one of these programs, **the information about premiums in this *Enrollee Handbook* may not apply to you**. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Enrollee Services at the number at the bottom of this page and ask for the “LIS Rider”.

H1. Plan premium

As an enrollee of your plan, you pay a monthly plan premium unless you qualify for Extra Help with your prescription drug costs. You won’t pay a monthly Plan premium (prescription drug plan premium) if you qualify for Extra Help. People with Medicare and Medicaid automatically qualify for Extra Help. Because you qualify for Extra Help, for 2026 the monthly premium for our plan is $0.

H2. Monthly Medicare Part B premium

Many enrollees are required to pay other Medicare premiums

As a member of UHC Dual Choice DC-Y2 (PPO D-SNP) you receive up to a $0.80 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 aren't 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'll receive a full credit for amounts you have paid.

Some enrollees are required to pay other Medicare premiums. As explained in **Section E** above to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most UHC Dual Choice DC-Y2 (PPO D-SNP) members, Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and Part B premium.

If Medicaid isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of the plan. This includes your premium for Medicare Part B. You may also pay a premium for Medicare Part A if you aren't eligible for premium free Medicare Part A. In addition, please contact Enrollee Services or your care navigator and inform them of this change.

H3. Part D Late Enrollment Penalty

Because you're dual-eligible, the LEP doesn't apply as long as you maintain your dual-eligible status, but if you lose status you may incur LEP. Some enrollees are required to pay a Part D late enrollment penalty. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you didn't have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it's 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'll have to pay this penalty for as long as you have Part D coverage.

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

You won't have to pay it if:

- You receive Extra Help from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information

may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

- **Note**: Any notice must state that you had "creditable" prescription drug coverage that's expected to pay as much as Medicare's standard prescription drug plan pays.
- **Note:** The following aren't 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 didn't have coverage. The penalty is 1% for every month that you didn't 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 (national base beneficiary premium). For 2026, this average premium amount is $38.99.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $32.74, which equals $4.58. This rounds to $4.60. This amount would be added to the monthly premium for someone with a Part D late enrollment penalty.

Three important things to note about the monthly Part D late enrollment penalty:

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

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

I. Your *Enrollee Handbook*

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

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

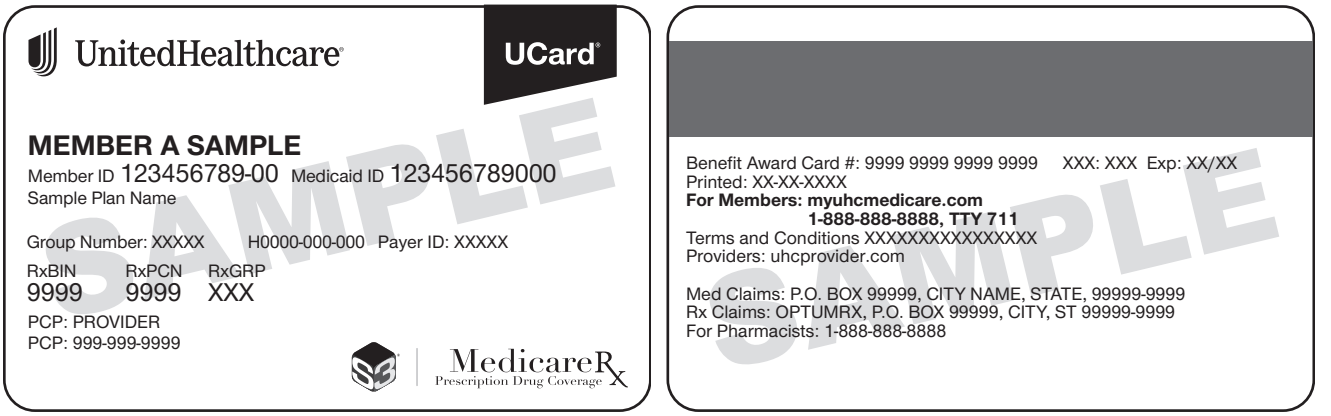
The contract is in effect for the months you're enrolled in our plan between January 1, 2026 and December 31, 2026.

J. Other important information you get from us

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

J1. Your UnitedHealthcare Enrollee UCard

Under our plan, you have one card for your Medicare and DC Medicaid services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:



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

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your DC Medicaid card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your UCard, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of your *Enrollee Handbook* to find out what to do if you get a bill from a provider.

Your UCard can be used to purchase healthy foods, over-the-counter (OTC) items, and to pay your utilities.

J2. *Provider and Pharmacy Directory*

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

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

Definition of network providers

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

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

Definition of network pharmacies

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

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

J3. *List of Covered Drugs*

Our plan has a *List of Covered Drugs*. We call it the **Drug List** for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The **Drug List** must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your **Drug List** unless they have been removed and replaced as described in **Chapter 5, Section E**. Medicare approved the UHC Dual Choice DC-Y2 (PPO D-SNP) **Drug List**.

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

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

J4. The *Explanation of Benefits*

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take **Chapter 6** of your *Enrollee Handbook* gives more information about the EOB and how it helps you track your drug coverage.

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

K. Keeping your enrollment record up to date

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

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network use your enrollment record to know what services and drugs are covered and your cost-sharing amounts. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

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

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

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

K1. Privacy of personal health information (PHI)

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

L. How other insurance works with our plan

Other insurance

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

Once each year, we'll 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's correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that isn't listed, please call Enrollee Services. You may need to give your plan enrollee ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

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

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

- No-fault insurance (including automobile insurance)

- Liability (including automobile insurance)
- Black lung benefits
- Workers' Compensation

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

Chapter 2: Important phone numbers and resources

Introduction

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

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A. Enrollee Services

CALL	**1-866-242-7726** This call is free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September We have free interpreter services for people who don't speak English.
TTY	**711** This call is free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September
FAX	**1-888-950-1169**
WRITE	United Healthcare Attention: Enrollee Services Department P.O. Box 30769 Salt Lake City, UT 84130-0769
WEBSITE	**MyUHC.com/CommunityPlan**

Contact Enrollee Services to get help with:

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

CALL	**1-866-242-7726** Calls to this number are free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September
TTY	**711** Calls to this number are free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September
WRITE	United Healthcare Appeal and Grievance Department Attn: Complaint and Appeals Department P.O. Box 6103, MS CA 120-0360 Cypress, CA 90630-0023
FAX	Standard **1-844-226-0356** Expedited **1-866-373-1081**

- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).
  - You can call us and explain your complaint at **1-866-242-7726**, TTY **711** .
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can also contact DC Medicaid with your complaint by contacting Dual Choice support at **202-442-9533**, TTY **711**, Monday–Friday, 9 a.m.–4:45 p.m.
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Enrollee Handbook*.
- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**

- the amount we pay for your drugs.

◦ This applies to your Medicare Part D drugs and DC Medicaid prescription drugs and over-the-counter drugs.

◦ For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your *Enrollee Handbook*.

- appeals about your drugs

◦ An appeal is a way to ask us to change a coverage decision.

◦ For more on making an appeal about your drugs, refer to **Chapter 9** of your *Enrollee Handbook*.

CALL	**1-866-242-7726** Calls to this number are free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September Expedited **1-855-409-7041**
TTY	**711** Calls to this number are free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September
WRITE	United Healthcare Part D Appeal and Grievance Department P.O. Box 6103, MS CA 120-0368 Cypress, CA 90630-0023
FAX	Standard **1-877-960-8235** Expedited **1-866-308-6296**

- complaints about your drugs

◦ You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.

◦ If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)

- You can send a complaint about our plan to Medicare. You can use an online form at medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your *Enrollee Handbook*.

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

B. Your Care Management Team

A care team can help you keep getting the care you need and want. A care team may include your doctor, a Care Manager, or other health person that you choose. Together, you and your Care Team will make your individualized Care Plan.

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

CALL	**1-866-242-7726** This call is free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September We have free interpreter services for people who don't speak English.
TTY	**711.** This call is free. 8 a.m.–8 p.m., 7 days a week, October–March; 8 a.m.–5:30 p.m., Monday–Friday, April–September
FAX	**1-888-950-1169**
WRITE	United Healthcare Attention: Enrollee Services Department P.O. Box 30769 Salt Lake City, UT 84130-0769
WEBSITE	**MyUHC.com/CommunityPlan**

Contact your care management team to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about transportation
- questions about getting covered services, including long-term services and support (LTSS)

C. DC State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In the District, the SHIP is called the DC State Health Insurance Assistance Program (SHIP).

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

CALL	**1-202-727-8370** Monday to Friday, 9:30 a.m.–4:30 p.m.
TTY	**711** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	250 E Street SW, Washington, DC 20024
EMAIL	**dacl@dc.gov**
WEBSITE	dacl.dc.gov/service/health-insurance-counseling

Contact the DC SHIP for help with:

- questions about Medicare
- DC SHIP counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - answer questions about switching plans,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

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

CALL	**1-888-396-4646** Monday to Friday, 9 a.m.–5 p.m.; weekends and holidays, 11 a.m.–3 p.m.
TTY	**1-888-985-2660** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	10820 Guilford RD, STE 202, Annapolis Junction, MD 20701
WEBSITE	**livantaqio.com**

Contact Commence Health BFCC-QIO for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

E. Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS. This agency contracts with Medicare Advantage organizations including our plan.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	**1-877-486-2048.** This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
CHAT LIVE	Chat live with **www.Medicare.gov/talk-to-someone**
WRITE	Write to Medicare at PO Box 1270, Lawrence, KS 66044
WEBSITE	medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventative services (like screenings, shots, or vaccines, and yearly “wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

F. DC Medicaid

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

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

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

CALL	**1-202-442-9533** Monday–Friday, 9 a.m.–4:45 p.m.
TTY	**711** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	441 4th ST NW, 900S, Washington, DC 20001
EMAIL	**DualChoice@dc.gov**
WEBSITE	dhcf.dc.gov/

G. Office of Health Care Ombudsman and Bill of Rights

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

CALL	**1-202-724-7491** Monday–Friday, 9 a.m.–4:45 p.m.
TTY	**711** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	441 4th Street, NW, Suite 250 North, Washington, DC 20001
EMAIL	**healthcareombudsman@dc.gov**
WEBSITE	healthcareombudsman.dc.gov

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

The Office of the DC Long-Term Care Ombudsman helps people get information and resources about nursing homes, assisted living facilities, and community residence facilities. The Long-Term Care Ombudsman also provides advocacy services to individuals receiving services through the District's Elderly and Persons with Physical Disabilities (EPD) Medicaid Waiver Program. The Office of the DC Long-Term Care Ombudsman isn't connected with our plan or any insurance company or health plan.

CALL	**202-434-2190** Calls are responded to within 24 hours or the next business day
WRITE	601 E Street, NW, Washington, DC 20049
EMAIL	DCOmbuds@aarp.org
WEBSITE	aarp.org/legal-counsel-for-elderly/what-we-do/info-2017/dc-long-term-care-ombudsman

I. Programs to Help People Pay for Drugs

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

I1. Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your drug plan costs. You don't need to do anything to get this Extra Help.

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

I2. AIDS Drug Assistance Program (ADAP)

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

I3. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January–December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same plan, you don't need to do anything to continue this option. "Extra Help" from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in this payment option, no matter your income level, and plans with drug coverage must offer this payment option. To learn more about this payment option, call Member Services at the phone number at the bottom of the page or visit Medicare.gov.

J. Social Security

Social Security determines Medicare elibility and handles Medicare enrollment.

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

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 their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	ssa.gov

K. Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the RRB, let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

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

L. Group insurance or other insurance from an employer

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

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

Chapter 3: Using our plan's coverage for your health care and other covered services

Introduction

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

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A. Information about services and providers

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

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

Network providers are providers who work with our plan. These providers agree to accept our payment. We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay only your share of the cost for covered services.

B. Rules for getting services our plan covers

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

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

- The care you get must be a **plan benefit**. This means we include it in our Benefits Chart in **Chapter 4** of your *Enrollee Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
    - In most cases, our plan must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services.
    - You don't need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, go to **Section D1** in this chapter).
- **You must get your care from network providers.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for the services provided. Here are some cases when this rule does not apply:

- We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to **Section I** in this chapter).
- If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. You must get approval from us before you start receiving care from an out-of-network provider. Contact your care navigator by calling Enrollee Services at toll-free **1-866-242-7726**. In this situation, we cover the care as if you got it from a network provider. For information about getting approval to use an out-of-network provider, go to **Section D4** in this chapter.
- We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. The cost-sharing you pay for dialysis can never be higher than the cost-sharing in Original Medicare. If you're outside our plan's service area and get the dialysis from a provider that's outside the plan's network, your cost-sharing can't exceed the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from an out-of-network provider the cost-sharing for the dialysis may be higher. If possible, call Enrollee Services at the number at the bottom of the page before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- You can go to a family planning provider of your choice even if they're out-of-network. No prior authorization is required.
- We cover post-stabilization services if you have an emergency medical condition, regardless of whether the provider is in or out of the network.

C. Your care management team

The care management team are people to help you (the enrollee) use your benefits to get the care and services you need. This includes helping you get additional benefits through your health plan that you may not have been able to get before joining UHC Dual Choice DC-Y2 (PPO D-SNP). The care navigator will work with you to make sure your health plan knows what you need and how you want to get your services, and will help you with questions you have about getting care. Your care navigator can also help connect you with community resources. Working with you and your care team, your care navigator will help you make an Individualized Care Plan (ICP) that will be updated if your needs and preferences change over time.

C1. What a care navigator is

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

- A single point of contact for enrollee assistance.
- A familiar and consistent partner for the enrollee.
- Help to address and resolve the enrolllees' healthcare and enrollees services questions.

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

C2. How you can contact your care navigator

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

C3. How you can change your care navigator

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

C4. What a case manager is

A nurse, doctor or social worker who works with you and your health care providers, care navigator and health plan to coordinate a health care plan for you. They can help make sure you get the care and services you need.

C5. How you can contact your case manager

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

C6. How you can change your case manager

You may request a change in your case manager if they're not right for you. Please call Enrollee Services at **1-866-242-7726**, TTY **711**, 8:00 a.m.–8:00 p.m., 7 days a week, Oct–Mar; 8:00 a.m.–5:30 p.m., Monday–Friday, Apr–Sept.

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care.

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

What's a PCP?

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

What types of providers may act as a PCP?

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

What's the role of my PCP?

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

It's important to call your PCP first when you need care. If you had a PCP before you signed up with UHC Dual Choice DC-Y2 (PPO D-SNP), please call Enrollee Services at **1-866-242-7726**. We can help you stay with that PCP if you want to.

Your choice of PCP

Picking your PCP

1. Pick a PCP at the time you enroll in the Community Plan program with UHC Dual Choice DC-Y2 (PPO D-SNP). This person will be your PCP while you're enrolled in UHC Dual Choice DC-Y2 (PPO D-SNP).
    - If your current PCP is a Provider in UHC Dual Choice DC-Y2 (PPO D-SNP)'s network, you may stay with that doctor
    - If you don't have a PCP, you can choose from a list of doctors in our Provider Directory or at connect.werally.com/state-plan-selection/uhc.medicaid/state

- Call Enrollee Services at 1-866-242-7726, TTY 711 if you need help in picking a doctor
- If you don't pick a PCP within the first 10 days of being in our plan, we'll choose a doctor for you. If you don't like the PCP we pick for you, you may change your PCP. Call Enrollee Services at 1-866-242-7726, TTY 711 to change your PCP.
- UHC Dual Choice DC-Y2 (PPO D-SNP) will send you a UCard. Your PCP's name and phone number will be included on the letter mailed out to you.

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

Option to change your PCP

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

If you want to change your PCP, call Enrollee Services or go online. If you need help picking a new PCP, Enrollee Services can help you. If the PCP is accepting additional plan enrollees, the change will become effective on the first day of the following month. You'll receive a new UCard that shows this change.

D2. Care from specialists and other network providers

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

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

Even though your PCP is trained to handle most common health care needs, there may be a time when you feel that you need to see a network specialist. **You don't need a referral from your PCP to see a network specialist or behavioral/mental health provider.** Although you don't need

a referral from your PCP to see a network specialist, your PCP can recommend an appropriate network specialist for your medical condition, answer questions you have regarding a network specialist's treatment plan and provide follow-up health care as needed. For coordination of care, we recommend you notify your PCP when you see a network specialist.

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

How to access your behavioral/mental health benefit

To directly access your behavioral/mental health benefits, please call the behavioral health number at 1-866-242-7726 TTY 711, 24 hours a day, 7 days a week. When you call, you'll speak with a representative who will check your eligibility and gather basic information about you and your situation. Depending on the help you need, a clinician may then talk with you about the problem you're experiencing and assess which provider and treatment would be appropriate for your situation. You may also ask your PCP to call the number on the back of your UCard and arrange a referral on your behalf. You may also call to receive information about in-network practitioners, subspecialty care and obtaining care after normal office hours. Confidentiality is maintained, so please be assured that personal information you discuss with their staff will be kept strictly confidential.

Services for alcohol or other drug problems

Problems with alcohol or other drugs are dangerous to your health and can be dangerous to the health of people around you. It's important to go to the doctor if you need help with these problems. UHC Dual Choice DC-Y2 (PPO D-SNP) will help you arrange for detoxification services and provide care coordination to help you get other services. To get services for these problems, you can:

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

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

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

- a chronic (ongoing) condition;
- a life-threatening mental or physical illness;
- a degenerative disease or disability;
- any other condition or disease that's serious or complex enough to require treatment by a specialist.

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

D3. When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll 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'll notify you if you visited that provider within the past three years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available open enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Covered services that may need approval in advance are marked in the Medical Benefits Chart.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider and to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

D4. Out-of-network providers

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

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

E. Long-term services and supports (LTSS)

You may be eligible for long-term care services and supports (LTSS). This includes care in a nursing facility or care in your own home. These services require prior authorization from UHC Dual Choice DC-Y2 (PPO D-SNP) and may require you to meet certain requirements.

Your LTSS Care Manager can help you with:

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

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

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

Mental health care helps when you feel depressed or anxious. To directly access your behavioral/mental health benefits, please call the behavioral health number on the back of your UCard 24 hours a day, 7 days a week. When you call, you'll speak with a representative who will check your eligibility and gather basic information about you and your situation. Depending on experiencing and assess which provider and treatment would be appropriate for your situation. You may also ask your PCP to call the number on the back of your UCard and arrange a referral on your behalf. You may also call to receive information about in-network practitioners, sub-specialty care and obtaining care after normal office hours. Confidentiality is maintained, so please be assured that personal information you discuss with their staff will be kept strictly confidential.

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

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

How to access your behavioral/mental health benefit

To directly access your behavioral/mental health benefits, please call the behavioral health number at **1-866-242-7726**, TTY **711**, 24 hours a day, 7 days a week. When you call, you'll speak with a representative who will check your eligibility and gather basic information about you and your situation. Depending on the help you need, a clinician may then talk with you about the problem you're experiencing and assess which provider and treatment would be appropriate for your situation.

You may also ask your PCP to call the number on the back of your UCard and arrange a referral on your behalf. You may also call to receive information about in-network practitioners, sub-specialty care and obtaining care after normal office hours. Confidentiality is maintained, so please be assured that personal information you discuss with their staff will be kept strictly confidential.

Services for alcohol or other drug problems

Problems with alcohol or other drugs are dangerous to your health and can be dangerous to the health of people around you. It's important to go to the doctor if you need help with these problems. UHC Dual Choice DC-Y2 (PPO D-SNP) will help you arrange for detoxification services and provide care coordination to help you get other services. To get services for these problems, you can:

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

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

G. How to get self-directed care

G1. What self-directed care is

Self-directed care is a model for long-term care services and supports (LTSS) that gives individuals more control over how and when they receive care. It's an alternative to traditional service delivery models, where an agency manages services.

G2. Who can get self-directed care (for example, if it's limited to waiver populations)

Medicaid pays for services through many programs that help you live in your own home or community. If you have a disability, are aged, or have a chronic condition such as diabetes, heart disease, or high blood pressure, you may be eligible to receive the care you need through one of the programs.

G3. How to get help in employing personal care providers (if applicable)

Talk with your case manager or your care navigator about your eligibility.

H. Transportation services

You have access to emergency and non-emergent transportation. If you need an ambulance to get to the emergency room, our plan covers that. Ground or air ambulance services that you may need in a medical emergency are covered. In specific circumstances, we may also cover nonemergency medical transportation if you have a written order from your doctor stating that the transportation is medically necessary. For example, someone with End-Stage Renal Disease may need medically necessary ambulance transport to a kidney dialysis facility. Non-emergency transportation is arranged through your enrollee services transportation SafeRide. Covered non-emergent transportation services include mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage). You can also ask your PCP or Care Navigator to help you to arrange this service. Please call us toll-free at 1-866-242-7726, TTY 711 to help arrange transportation. Available 8 a.m.–8 p.m.: 7 days Oct–Mar; 8:00 a.m.–5:30 p.m., M–F Apr–Sept. We have free interpreter services for people who don't speak English.

I. Covered services in a medical emergency, when urgently needed, or during a disaster

I1. Care in a medical emergency

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

- serious risk to your life and, if you're pregnant, loss of an unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You **don't** need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories, from any provider with an appropriate state license even if they're not part of our network.

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

Covered services in a medical emergency

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. To learn more, refer to the Medical Benefits Chart in **Chapter 4** of your *Enrollee Handbook*.

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

When you receive emergency care in the United States, after the emergency is over you're 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'll pay the higher out-of-network cost-sharing.

When you receive emergency care outside of the United States under the worldwide emergency benefit, only the medical services directly related to the immediate medical emergency are covered while you remain in a foreign country. Follow-up care received outside of the United States after your condition has been stabilized is generally not covered, even if the care is related to the original emergency. Coverage is limited to emergency services required to stabilize your condition. Any care received beyond stabilization must occur within the United States to be eligible for coverage.

Getting emergency care if it wasn't an emergency

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

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

- You use a network provider **or**

- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

I2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan's service area

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

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

If it isn't possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care you get from an out-of-network provider.

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

Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

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

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

I3. 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're still entitled to care from our plan.

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

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

J. What if you're billed directly for covered services

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

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

J1. What to do if our plan does not cover services

Our plan covers all services:

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

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

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

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

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

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

K. Coverage of health care services in a clinical research study

K1. Definition of a clinical research study

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

When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study through our plan). If you want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

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

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

K2. Payment for services when you're in a clinical research study

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

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

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

K3. More about clinical research studies

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

L. How your health care services are covered in a religious non-medical health care institution

L1. Definition of a religious non-medical health care institution

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

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

L2. 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're against getting medical treatment or treatment that's "non-excepted."

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

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

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

M. Durable medical equipment (DME)

M1. DME as a member of our plan

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

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As an enrollee of our plan, you usually **won't** own the rented DME, no matter how long you rent it.

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

M2. DME ownership if you switch to Original Medicare

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

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

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

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you**

need to make after leaving our plan.

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

M3. Oxygen equipment benefits as an enrollee of our plan

If you qualify for oxygen equipment covered by Medicare, we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

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

M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

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

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

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

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

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

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

Chapter 4: Medical Benefits Chart

Introduction

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

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A. Your covered services and your out-of-pocket costs

This chapter tells you about services our plan covers and how much you pay for each service. You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of your *Enrollee Handbook*.

For some services, you're charged an out-of-pocket cost called a copay. This is a fixed amount (for example, $5) you pay each time you get that service. You pay the copay at the time you get the medical service.

- **Your in-network maximum out-of-pocket amount is $0.** This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from network providers.
- **Your combined maximum out-of-pocket amount is $0 or $13,900.** This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount.

The amounts you pay for plan premium and for your Part D drugs don't count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you pay $0 or $13,900 for covered services, you'll have 100% coverage and won't 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 our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by DC Department of Human Services (Medicaid) or another third party).

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

Grace Period

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

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

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

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

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

A1. During public health emergencies

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

B. Rules against providers charging you for services

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

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

C. About our plan's Medical Benefits Chart

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

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

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

- For new enrollees, the 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 began with an out-of-network provider.
- You have a primary care provider (PCP) or a care team that's providing and managing your care.
- If you're receving treatment authorized and covered by DC Medicaid at the time of enrollment in this plan, you may continue this treatment, regardless of whether the provider is in UHC Dual Choice DC-Y2 (PPO D-SNP)'s provider network until the course of treatment is concluded, or for 30 days, whichever is longer. If your provider isn't currently in UHC Dual Choice DC-Y2 (PPO D-SNP)'s network, then you may be asked to select a new provider that's within UHC Dual Choice DC-Y2 (PPO D-SNP)'s provider network.
- If your health care provider leaves UHC Dual Choice DC-Y2 (PPO D-SNP)'s network, we'll notify you within 15 calendar days, so that you have time to select another provider. If UHC Dual Choice DC-Y2 (PPO D-SNP) terminates your provider, we'll notify you within 30 calendar days prior to the effective date of termination.
- We cover some services listed in the Medical Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). 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.
- If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.
- If you're within our plan's 90-day period of deemed continued eligibility, we will continue to provide all Medicare Advantage and DC Medicaid plan-covered benefits. During this time, we will assist you to regain Medicaid eligibility. If you regain Medicaid eligibility after we disenroll you from our Medicare coverage you'll need to contact us to reenroll in the plan.

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

- Because UHC Dual Choice DC-Y2 (PPO D-SNP) participates in D-SNP Healthy Food, you'll be eligible for the following WHP services, including advance care planning (ACP) services:
  - What are ACP services?
- Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in his situation. This means that, if you want to, you can:
  - Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
  - Give your doctors written instructions about how you want them to handle your medical are if you become unable to make decisions for yourself.

- You may get advance care planning assistance by contacting Enrollee Services at **1-866-242-7726** TTY **711**.

- If you're diagnosed with any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
  - **Qualifying conditions are:** Diabetes mellitus (type 1 or type 2), cardiovascular disorders, chronic heart failure, chronic hypertension (chronic high blood pressure), chronic hyperlipidemia (chronic high cholesterol), autoimmune disorders, cancer, chronic alcohol use disorder and other substance use disorders (SUDs), chronic gastrointestinal disease, chronic kidney disease (CKD), chronic lung disorders, chronic and disabling mental health conditions, dementia, HIV/AIDS, immunodeficiency and immunosuppressive disorders, Myasthenia Gravis/Myoneural Disorders and Guillain- Barre Syndrome/Inflammatory and Toxic Neuropathy, neurologic disorders, overweight, obesity and metabolic syndrome, post-organ transplantation care, severe hematologic disorders stroke, conditions associated with cognitive impairment, and conditions with functional challenges and require similar services.
  - Your eligibility will be determined after you enroll in this plan. We'll validate that you have one or more of the qualifying chronic conditions from your treating providers. In addition, we'll confirm you meet additional criteria including high-risk for hospitalization or serious health outcomes and require intensive care coordination, such as help managing multiple providers or medications.
  - For more detail, go to the Special Supplemental Benefits for the Chronically Ill row in the Medical Benefits Chart below.
  - Contact us to find out exactly which benefits you may be eligible for.

All preventive services are free. This apple shows the preventive services in the Medical Benefits Chart.

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

D. Our plan's Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In-Network** There is no coinsurance, copayment, or deductible for enrollees eligible for this preventive screening. **Out-of-Network** $0 copayment or 40% coinsurance for enrollees eligible for this preventive screening. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Acupuncture We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. Generally, Medicare-covered acupuncture services aren't covered when provided by an acupuncturist or chiropractor. **Provider Requirements:** Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable district requirements and have: **This benefit is continued on the next page**	**In-Network** *You'll pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/ practitioner services, including doctor's office visits") depending on if you receive services from a primary care physician or specialist.††* **Out-of-Network** *You'll 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.*

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Acupuncture (continued) • 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. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	**In-Network** *There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.* **Out-of-Network** *$0 copayment or 40% 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.*

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Ambulance services Medicare-covered ambulance services within the United States, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter) ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Outside of the United States, our worldwide emergency benefit covers emergency ambulance transportation only from the scene of an emergency to the nearest medical treatment facility within the foreign country. Transportation back to the United States from another country isn't covered, regardless of whether that transportation is via ambulance or some other method of transportation. Generally, you'll pay the full cost of any emergency ambulance services received outside of the United States at the time you receive the services and then you'll need to request reimbursement from us. Payment requests that we receive from intermediaries, claims management companies or third-party billers for services that you received outside of the United States aren't reimbursable.	*$0 copayment for each one-way Medicare-covered ground trip (in-network).* *$0 copayment or 20% of the total cost for each one-way Medicare-covered ground trip (out-of-network).* *$0 copayment for each one-way Medicare-covered air trip (in-network).* *$0 copayment or 20% of the total cost for each one-way Medicare-covered air trip (out-of-network).* *You pay these amounts until you reach the out-of-pocket maximum.* *All Medicare-covered trips (in or out-of-network) will apply to the in-network out-of-pocket maximum.* *Your provider may need to obtain prior authorization for non-emergency transportation.*
Annual routine physical exam Includes comprehensive physical examination and evaluation of status of chronic diseases. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. Annual Routine Physical Exam visits don't need to be scheduled 12 months apart but are limited to one in or out-of-network visit each calendar year.	**In-Network** $0 copayment for a routine physical exam each year. **Out-of-Network** 40% coinsurance for a routine physical exam each year.*

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Covered Service	What you pay
Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Welcome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months. 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.	**In-Network** *There is no coinsurance, copayment, or deductible for the annual wellness visit.* **Out-of-Network** *$0 copayment or 40% coinsurance for the annual wellness visit.* *You pay these amounts until you reach the out-of- pocket maximum.*
Audiologist Audiologist exams and evaluations. See also Hearing Benefit.	*$0*
Auxiliary aid services for the hearing and visually impaired If you have trouble hearing, call Enrollee Services at **1-866- 242-7726**, TTY **711**. If you have trouble seeing, call Enrollee Services at **1-866-242-7726**, TTY **711**. We can give you information on an audio tape, in braille or in large print.	*$0*

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

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Covered Service	What you pay
Behavioral Health (continued) Outpatient services: ◦ emergency department services ◦ case management services ◦ pregnancy related services ◦ outpatient alcohol and drug abuse treatment (clinic and OLP services) • Physician services: ◦ diagnostic and assessment services ◦ individual/group/family counseling ◦ federally quaified health center FQHC services ◦ medication/Somatic treatment **Services Payable by Department of Behavioral Health (DBH):** • Community-Based Interventions • Multi-Systemic Therapy (MST) • Assertive Community Treatment (ACT) • Transitional Assertive Community Treatment (TACT) • Community Support • Recovery Support Services • Vocational Supported Employment • Clubhouse Services • Trauma Recovery Empowerment Model (TREM) • Trauma Systems Therapy (TST) • Functional Family Therapy (FFT) **This benefit is continued on the next page**	

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Behavioral Health (continued) • Outpatient Rehabilitation services • Other Services Provided by DBH	
Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement. **Out-of-Network** $0 copayment or 40% coinsurance for the Medicare-covered bone mass measurement. You pay these amounts until you reach the out-of-pocket maximum.
Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months • clinical breast exams once every 24 months	**In-Network** *There is no coinsurance, copayment, or deductible for covered screening mammograms.* **Out-of-Network** *$0 copayment or 40% coinsurance for screening mammograms.* *You pay these amounts until you reach the out-of-pocket maximum.*

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Covered Service	What you pay
Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	**In-Network** There is no coinsurance, copayment, or deductible for each Medicare-covered cardiac rehabilitative visit.†† **Out-of-Network** $0 copayment or 40% coinsurance for each Medicare-covered cardiac rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum.
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you're eating well.	**In-Network** There is no coinsurance, copayment, or deductible for the cardiovascular disease preventive benefit. **Out-of-Network** $0 copayment or 40% coinsurance for the cardiovascular disease preventive benefit. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Cardiovascular (heart) disease screening tests We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	**In-Network** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that's covered once every five years. **Out-of-Network** $0 copayment or 40% coinsurance for cardiovascular disease testing that's covered once every five years. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Chronic care management services, including chronic pain management and treatment plan services If you have serious chronic conditions and receive chronic care management services, your provider develops a monthly comprehensive care plan that lists your health problems and goals, providers, medications, community services you have and need, and other information about your health. Your provider also helps coordinate your care when you go from one health care setting to another.	For your monthly chronic care management plan, you'll 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 the type of provider who developed your plan.†† For any care recommended under your plan, you'll pay the applicable cost-sharing. Services recommended under chronic pain management plans may include (but aren't limited to) primary care services, specialist physician services, physical therapy, occupational therapy, lab or diagnostic tests, or prescription drugs (as described under "Physician/practitioner services, including doctor's office visits", "Outpatient rehabilitation services", "Outpatient diagnostic tests and therapeutic services and supplies", or "Medicare Part B Drugs", or see Chapter 6 for what you pay for applicable Part D drugs).††

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months • For asymptomatic women between the ages of 30 and 65: HPV Testing once every 5 years, in conjunction with the Pap test	**In-Network** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. **Out-of-Network** $0 copayment or 40% coinsurance for Medicare-covered preventive Pap and pelvic exams. You pay these amounts until you reach the out-of-pocket maximum.
Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment • excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation.	**In-Network** $0 copayment for each Medicare-covered visit.†† **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered visit. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Colorectal cancer screening We pay for the following services: • Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonsocopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. **This benefit is continued on the next page**	**In-Network** *There is no coinsurance, copayment, or deductible for Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes an outpatient diagnostic colonoscopy.* **Out-of-Network** $0 copayment or 40% 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.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Colorectal cancer screening (continued) • 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 pateints 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	If you have a prior history of colon cancer, or have had polyps removed during a previous colonoscopy, ongoing colonoscopies are considered diagnostic and are subject to cost sharing as described under the outpatient diagnostic colonoscopy benefit below. Therefore, the screening colonoscopy benefit isn't available for members who have signs or symptoms prior to the colonoscopy. A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the outpatient diagnostic colonoscopy cost sharing shown below.
Outpatient diagnostic colonoscopy	**In-network** *There is no coinsurance, copayment, or deductible for each Medicare-covered diagnostic colonoscopy.††* **Out-of-network** *You'll 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 the service.††*

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Covered Service	What you pay
Dental services We pay for the following services: • general dental examinations/preventive services • surgical services and extractions • emergency care • fillings • reline or rebase of a removable denture, limited to two (2) in five (5) years unless there is a prior authorization • complete radiographic survey, full series of X-rays or panoramic X-ray of the mouth, limited to once every three years; additional requires prior authorization • full mouth debridement • oral prophylaxis, limited to once every six months • bitewing series • palliative treatment • sealant application • removable partial and full dentures • root canal treatment • periodontal scaling and root planning • removal of impacted teeth • initial placement or replacement of a removable prosthesis, one per arch every five (5) years per beneficiary, unless the prosthesis was missing, stolen, damaged or can't be modified • a removable partial prosthesis **This benefit is continued on the next page**	**In-network** $0 copayment for Medicare-covered dental services.[††] **Out-of-network** $0 copayment or 40% coinsurance for Medicare-covered dental services. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Dental services (continued) • dental implants, require authorization We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.	
Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	**In-Network** *There is no coinsurance, copayment, or deductible for an annual depression screening visit.* **Out-of-Network** *$0 copayment or 40% coinsurance for an annual depression screening visit.* *You pay these amounts until you reach the out-of-pocket maximum.*

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening.	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. **Out-of-Network** $0 copayment or 40% coinsurance for the Medicare-covered diabetes screening tests. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose: continuous glucose monitors (CGMs), blood glucose monitors (BGMs), blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • You can get certain CGMs from your pharmacy, and all are available from a DME provider at the same cost. If you have Type 1 diabetes, you don't need prior authorization. For Type 2 diabetes and other conditions, you'll need a prior authorization for CGMs from a DME provider. Prior authorizations for CGMs and supplies are approved for 12 months. Or you can get certain CGMs from a pharmacy without prior authorization if your claim history includes insulin or any type of CGM device part (ex. sensors, transmitters). • For details on Medicare's CGM requirements, visit medicare.gov/coverage/therapeutic-continuousglucosemonitors. **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered continuous glucose monitor (CGM) and supplies with an approved prior authorization. There are no brand limitations for CGMs.†† $0 copayment for each Medicare-covered blood glucose monitor (BGM).†† For BGMs, we only cover Contour® and Accu-Chek® brands. Other BGM brands aren't covered by our plan. Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide. Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus. You pay a $0 for the diabetes self-management training preventive benefit. You pay a $0 for Medicare-covered Continuous Glucose Monitors or supplies in accordance with Medicare guidelines. There are no brand limitations for Continuous Glucose Monitors.††

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Diabetic self-management training, services, and supplies (continued) We cover the BGMs and test strips in this list. We don't usually cover other BGM brands unless your provider tells us it's medically necessary. If you're new to the plan and using a brand that isn't on our list, you can request a temporary supply within the first 90 days of enrollment while you talk with your provider. They can help you decide if any of the preferred brands work for you. If you or your provider think it's medically necessary for you to keep using a different brand, you can request a coverage exception to have it covered for the rest of the plan year. After the first 90 days of enrollment, non-preferred products will only be covered with an approved exception. If you (or your provider) don't agree with the plan's coverage decision, you or your provider can file an appeal. You can also file an appeal if you don't agree with your provider's decision about the appropriate product or brand for your condition. (For more information about appeals, see **Chapter 9.** • For people with diabetes who have severe diabetic foot disease, we pay for the following: ◦ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, or ◦ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) **This benefit is continued on the next page**	You pay a $0 for each pair of Medicare-covered therapeutic shoes.†† **Out-of-Network** $0 copayment or 20% coinsurance for each Medicare-covered continuous glucose monitor (CGM) and supplies with an approved prior authorization. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 20% coinsurance for each Medicare-covered blood glucose monitor (BGM). You pay these amounts until you reach the out-of-pocket maximum. For cost-sharing applicable to insulin and syringes, see Chapter 6 - What you pay for your Part D prescription drugs. $0 copayment or 20% coinsurance for each pair of Medicare-covered therapeutic shoes. $0 copayment or 40% coinsurance for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Diabetic self-management training, services, and supplies (continued) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services. • 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.	

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of your *Enrollee Handbook* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment • incontinence supplies (diapers/wipes) • nutritional supplements • enteral formula • bath chairs • tub and shower grab bars **This benefit is continued on the next page**	**In-Network** $0 copayment for Medicare-covered benefits.†† Your cost-sharing for Medicare oxygen equipment coverage is $0 copayment, every time you get covered equipment or supplies.†† Your cost-sharing won't change after being enrolled for 36 months. If prior to enrolling in our plan you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in our plan is $0 copayment.†† **Out-of-Network** $0 copayment or 20% coinsurance for Medicare-covered benefits. Your cost sharing for Medicare oxygen equipment coverage is $0 copayment or 20% coinsurance every time you get covered equipment or supplies. Your cost sharing won't change after being enrolled for 36 months.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued) Other items may be covered. We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.	If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in our plan, your cost sharing in our plan is $0 copayment or 20% coinsurance. You pay these amounts until you reach the out-of- pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to evaluate or treat a medical emergency. A medical emergency is an illness, injury, severe pain or medical condition that's quickly getting worse. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your life or to that of your unborn child; **or** • serious harm to bodily functions; **or** • loss of a limb, or loss of function of a limb. In the case of a pregnant woman in active labor, when: • There isn't enough time to safely transfer you to another hospital before delivery. • A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. Worldwide emergency coverage for emergency department services outside of the United States. • This includes emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. • Transportation back to the United States from another country isn't covered. **This benefit is continued on the next page**	$0 copayment for each emergency room visit. You don't pay this amount if you're admitted to the hospital within 24 hours for the same condition. If you're admitted to a hospital, you'll pay cost-sharing as described in the "Inpatient hospital care" section in this benefit chart. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must either receive authorization to stay at the out-of-network hospital or move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you're stabilized. If you stay at the out-of-network hospital, your stay will be covered but you'll pay the out-of-network cost-sharing amount for the part of your stay after you're stabilized. $0 copayment for worldwide coverage for emergency services outside of the United States. Please see **Chapter 8, Section A** for expense reimbursement for worldwide services.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Emergency care (continued) • Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures aren't covered. • Services provided by a dentist aren't covered. • Provider access fees, appointment fees and administrative fees aren't covered. • Generally, you'll pay the full cost of emergency services received outside of the United States at the time you receive services and then will request reimbursement from us. Payment requests we receive from intermediaries, claims management companies or third-party billers for services received outside of the United States aren't reimbursable.	

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

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

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Family planning services (continued) We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	
Fitness Program Your fitness program helps you stay active and connected at the gym, from home or in your community. It's available to you at no cost and includes: • Free gym membership at core locations • Access to a large national network of gyms and fitness locations • On-demand workout videos and live streaming fitness classes • Online memory fitness activities See **Chapter 11** for the fitness program terms and conditions of coverage. You can get more information by viewing the **Vendor Information Sheet** at **MyUHC.com/CommunityPlan** or by calling Enrollee Services to have a paper copy sent to you.	$0 copayment A home-delivered fitness kit is available if you live 15 miles or more from a network gym or fitness location. Coverage is limited to in-network locations only.
Routine hearing exam This benefit covers one exam every year. This benefit is combined in and out-of-network.	**In-Network** $0 copayment **Out-of-Network** 30% coinsurance*

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	**In-Network** $0 copayment for each Medicare-covered exam.†† $0 copayment **Out-of-Network** $0 copayment for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum.
HIV screening We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. If you're pregnant, we pay for up to three HIV screening tests during a pregnancy.	**In-Network** *There is no coinsurance, copayment, or deductible for enrollees eligible for Medicare-covered preventive HIV screening.* **Out-of-Network** *$0 copayment or 40% coinsurance for enrollees eligible for Medicare-covered preventive HIV screening.* *You pay these amounts until you reach the out-of-pocket maximum.*

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

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Covered Service	What you pay
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies	**In-Network** *$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met.††* **Out-of-Network** *$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met.*

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Covered Service	What you pay
Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but aren't limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. **This benefit is continued on the next page**	**In-Network** *You'll pay the cost-sharing that applies to primary care services, specialist physician services, or home health (as described under "Physician/practitioner services, including doctor's office visits" or "Home health agency care") depending on where you received administration or monitoring services.††* *See "Durable medical equipment" earlier in this chart for any applicable cost-sharing for equipment and supplies related to home infusion therapy.††* *See "Medicare Part B prescription drugs" later in this chart for any applicable cost-sharing for drugs related to home infusion therapy.††* *See* **Chapter 6** *for any applicable cost-sharing for Part D drugs related to home infusion therapy.*

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Home infusion therapy (continued)	**Out-of-Network** You'll pay the cost-sharing that applies to primary care services, specialist physician services, or home health (as described under "Physician/practitioner services, including doctor's office visits" or "Home health agency care") depending on where you received administration or monitoring services.†† See "Durable medical equipment" earlier in this chart for any applicable cost-sharing for equipment and supplies related to home infusion therapy.†† See "Medicare Part B prescription drugs" later in this chart for any applicable cost-sharing for drugs related to home infusion therapy. See **Chapter 6** for any applicable cost-sharing for Part D drugs related to home infusion therapy.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare:** • Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay our plan's cost-sharing amount for these services. **This benefit is continued on the next page**	*When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not UHC Dual Choice DC-Y2 (PPO D-SNP).*

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Hospice care (continued) **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Enrollee Handbook*. **Note:** If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that isn**'t** related to your terminal prognosis. Getting your non-hospice care through our network providers will lower your share of the costs for the services. Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.	
Immunizations We pay for the following services: • pneumonia vaccine • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you're at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you're at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of your *Enrollee Handbook* to learn more.	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.

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Covered Service	What you pay
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered hospital stay for unlimited days each time you're admitted.†† Medicare hospital benefit periods don't apply. (See definition of benefit periods in the chapter titled Definitions of important words.) For inpatient hospital care, the cost-sharing described above applies each time you're admitted to the hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you're covered for unlimited days as long as the hospital stay is covered in accordance with plan rules. You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Inpatient hospital care (continued) The plan's hospital network for organ transplant services is different than the network shown in the `Hospitals' section of your **Provider Directory**. Some hospitals in the plan's network for other medical services aren't in the plan's network for transplant services. For information on network facilities for transplant services, please call UHC Dual Choice DC-Y2 (PPO D-SNP) Enrollee Services at **1-866-242-7726**, TTY **711**. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside the service area. If our in-network transplant providers are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If UHC Dual Choice DC-Y2 (PPO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • blood, including storage and administration. Coverage begins with the first pint of blood that you need. • physician services **This benefit is continued on the next page**	**Out-of-Network** $0 copayment or $2,230 for each Medicare-covered hospital stay for unlimited days each time you're admitted. You'll pay these amounts until you reach the out-of-pocket maximum. Medicare hospital benefit periods don't apply. (See definition of benefit periods in the chapter titled Definitions of important words.) For inpatient hospital care, the cost-sharing described above applies each time you're admitted to the hospital. A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you're covered for unlimited days as long as the hospital stay is covered in accordance with plan rules. Outpatient observation cost sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Inpatient hospital care (continued) **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare Hospital Benefits. This fact sheet is available at Medicare.gov/publications/11435-Medicare-HospitalBenefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227).	

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • Inpatient substance abuse services **This benefit is continued on the next page**	**In-Network** $0 copayment up to 90 days per benefit period, plus an additional 60 lifetime reserve days.†† Medicare hospital benefit periods are used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in the chapter titled Definitions of important words.) However, the cost-sharing described above applies each time you're admitted to the hospital, even if you're admitted multiple times within a benefit period. **Out-of-Network** $0 copayment or $2,080 copayment for Medicare-covered hospital care each time you're admitted, up to 90 days per benefit period. Plus an additional 60 lifetime reserve days. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Inpatient services in a psychiatric hospital (continued)	Medicare hospital benefit periods are used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in the chapter titled Definitions of important words.) However, the cost-sharing described above applies each time you're admitted to the hospital, even if you're admitted multiple times within a benefit period.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We don't pay for your inpatient stay if you have used all of your inpatient benefit or if the stay isn't reasonable and medically necessary. However, in certain situations where inpatient care isn't covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Enrollee Services. We pay for the following services, and maybe other services not listed here: • doctor services • diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • surgical dressings • splints, casts, and other devices used for fractures and dislocations • prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: ◦ an internal body organ (including contiguous tissue), or ◦ the function of an inoperative or malfunctioning internal body organ. **This benefit is continued on the next page.**	When your stay is no longer covered, these services will be covered as described in the following sections: Please refer below to Physician/ practitioner services, including doctor's office visits. Please refer below to Outpatient diagnostic tests and therapeutic services and supplies. Please refer below to Prosthetic devices and related supplies. Please refer below to Outpatient rehabilitation services.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued) • leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition • physical therapy, speech therapy, and occupational therapy	

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Covered Service	What you pay
Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of your *Enrollee Handbook*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B pays for some drugs for dialysis. For information, refer to "Medicare Part B drugs" in this chart.	**In-Network** $0 copayment for Medicare-covered benefits. $0 copayment for Medicare-covered benefits.†† These services will be covered as described in the following sections: Please refer to Inpatient hospital care. Please refer to Durable medical equipment and related supplies. Please refer to Home health agency care. **Out-of-Network** $0 copayment or 40% coinsurance for Medicare-covered kidney disease education services. $0 copayment or 20% coinsurance for Medicare-covered outpatient dialysis treatments. $0 copayment or 40% coinsurance for self-dialysis training. You pay these amounts until you reach the out-of-pocket maximum. Please refer to Durable medical equipment and related supplies. Please refer to Home health agency care.

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Covered Service	What you pay
Lung cancer screening with low dose computed tomography (LDCT) Our plan pays for lung cancer screening every 12 months if you: • are aged 50–77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	**In-Network** *There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.* **Out-of-Network** *$0 copayment or 40% coinsurance for the Medicare-covered counseling and shared decision making visit or for the LDCT.* *You pay these amounts until you reach the out-of-pocket maximum.*
Meal benefit This benefit can be used immediately following a covered inpatient hospital or skilled nursing facility (SNF) stay if recommended by a provider. Benefit guidelines: • Receive up to 28 home-delivered meals for up to 14 days • First meal delivery may take up to 72 hours after ordered • Referrals must be placed within 30 calendar days of discharge Call Enrollee Services to get more information.	*$0 copayment* *Prior authorization is required.* *Home-delivered meals are available nationwide.*

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Covered Service	What you pay
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	**In-Network** *There is no coinsurance, copayment, or deductible for enrollees eligible for Medicare-covered medical nutrition therapy services.* **Out-of-Network** *$0 copayment or 40% coinsurance for enrollees eligible for Medicare-covered medical nutrition therapy services.* *You pay these amounts until you reach the out-of-pocket maximum.*
Medicare Diabetes Prevention Program (MDPP) Our plan pays for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	*There is no coinsurance, copayment, or deductible for the MDPP benefit.*

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Covered Service	What you pay
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • the Alzheimer's drug, Leqembi (generic lecanemab) which is given intravenously (IV). • 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. Medicare Part D covers immunosuppressive drugs if Part B does not cover them • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself • some antigens: Medicare covers antigens if a doctor prepares them and a properly instructued person (who could be you, the patient) gives them under appropriate supervision **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered chemotherapy drug and the administration of that drug.†† $0 copayment for each Medicare-covered Part B drug.†† Additionally, for the administration of that drug, you'll 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. **Out-of-Network** $0 copayment or 20% 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. $0 copayment for each Medicare-covered Part B drug.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Medicare Part B prescription drugs (continued) • 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). 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) covered under Medicare Part B • calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar • 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 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) • IV immune globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (IV and tube feeding) **This benefit is continued on the next page**	Additionally, for the administration of that drug, you'll pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/practitioner services, includingdoctor'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.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Medicare Part B prescription drugs (continued) We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **Chapter 5** of your *Enrollee Handbook* explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of your *Enrollee Handbook* explains what you pay for your drugs through our plan.	
Nurse Hotline Nurse Hotline services available, 24 hours a day, 7 days a week. Speak to a registered nurse (RN) about your medical concerns and questions. You can get more information by viewing the **Vendor Information Sheet** at **MyUHC.com/CommunityPlan** or by calling Enrollee Services to have a paper copy sent to you.	$0 copayment

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Nursing facility care A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Services that we pay for include, but aren't limited to, the following: • full-time skilled nursing facility (SNF) care • long term custodial care • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given 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 • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered SNF stay, up to 100 days. You're covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. **Out-of-Network** $0 copayment for each Medicare-covered SNF stay, up to 100 days. You're 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.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Nursing facility care (continued) • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	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.
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	**In-Network** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. **Out-of-Network** $0 copayment or 40% coinsurance for preventive obesity screening and therapy. You pay these amounts until you reach the out-of-pocket maximum.

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Covered Service	What you pay
Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0 copayment for Medicare-covered opioid treatment program services.††

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Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations **Note:** There is no separate charge for medical supplies routinely used in the course of an office visit and included in the provider's charges for that visit (such as bandages, cotton swabs, and other routine supplies.) However, supplies for which an appropriate separate charge is made by providers (such as, chemical agents used in certain diagnostic procedures) are subject to cost-sharing as shown. • lab tests • blood, including storage and administration (this means processing and handling of blood). Coverage begins with the first pint of blood that you need. • diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition • other outpatient diagnostic tests ◦ non-radiological diagnostic services **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered standard X-ray service.†† $0 copayment for each Medicare-covered radiation therapy service.†† $0 copayment for each Medicare-covered medical supply.†† $0 copayment for Medicare-covered lab services.†† $0 copayment for Medicare-covered blood services.†† $0 copayment for Medicare-covered non-radiological diagnostic services.†† Examples include, but aren't limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests. $0 copayment for Medicare-covered radiological diagnostic services, not including Xrays.††

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Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued) ◦ Radiological diagnostic services, not including X-rays performed in a physician's office or at a freestanding facility (such as a radiology center or medical clinic). • The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but aren't limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms, and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies). In addition, for the administration of blood infusion, you'll 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 **This benefit is continued on the next page**	The diagnostic radiology services require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but aren't limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies). **Out-of-Network** $0 copayment or 40% coinsurance for each Medicare-covered standard X-ray service. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 20% coinsurance for each Medicare-covered radiation therapy service. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 20% coinsurance for each Medicare-covered medical supply. You pay these amounts until you reach the out-of-pocket maximum.

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Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued) **This benefit is continued on the next page**	$0 copayment for Medicare-covered lab services. $0 copayment or 40% coinsurance for Medicare-covered blood services. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 40% for Medicare-covered non-radiological diagnostic services. Examples include, but aren't limited to EKG's, pulmonary function tests, home or lab-based sleep studies, and treadmill stress tests. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 40% coinsurance for Medicare-covered radiological diagnostic services, not including X-rays, performed in a physician's office or at a free-standing facility (such as a radiology center or medical clinic). You pay these amounts until you reach the out-of-pocket maximum.

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Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued)	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 aren't limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).
Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. The services must meet 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're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet **Medicare Hospital Benefits**. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf	Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.

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

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Covered Service	What you pay
Outpatient hospital services (continued)	Please refer to Medicare Part B prescription drugs and Physician/practitioner services, including doctor's office visits or Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers. Outpatient observation cost-sharing is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.

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Covered Service	What you pay
Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws In addition, Medicaid may cover the following services: • Behavioral Health Emergency Services • Observation • Community Support Services • Federally Qualified Health Center (FQHC) Services • Day Treatment • Residential programs • Crisis stabilization • Psychiatric day treatment	**In-Network** *$0 copayment for each Medicare-covered* **individual** *therapy session.††* *$0 copayment for each Medicare-covered* **group** *therapy session.††* **Out-of-Network** *$0 copayment or 30% coinsurance for each Medicare-covered* **individual** *therapy session.* *$0 copayment or 30% coinsurance for each Medicare-covered* **group** *therapy session.* *You pay these amounts until you reach the out-of-pocket maximum.*

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

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Covered Service	What you pay
Outpatient substance use disorder services We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment • Clinical and Other Licensed Practitioners (OLP) • Outpatient rehabilitation services are covered under the Department of Behavioral Health (DBH)	**In-Network** $0 copayment for each Medicare-covered **individual** therapy session.†† $0 copayment for each Medicare-covered **group** therapy session.†† **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered **individual** therapy session. $0 copayment or 30% coinsurance for each Medicare-covered **group** therapy session. You pay these amounts until you reach the out-of-pocket maximum.

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Covered Service	What you pay
Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. **This benefit is continued on the next page**	**In-Network** $0 copayment for Medicare-covered surgery or other services provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges.†† $0 copayment for Medicare-covered surgery or other services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges.†† Outpatient surgical services that can be delivered in an available ambulatory surgery center must be delivered in an ambulatory surgery center unless a hospital outpatient department is medically necessary. $0 copayment for 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.††

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Covered Service	What you pay
Outpatient surgery (continued)	**Out-of-Network** $0 copayment or 40% coinsurance for Medicare-covered surgery or other services provided to you at an ambulatory surgical center, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 40% coinsurance for Medicare-covered surgery or other services provided to you at an outpatient hospital, including but not limited to hospital or other facility charges and physician or surgical charges. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 40% 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.

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Covered Service	What you pay
Over-the-counter (OTC) credit With this benefit, you'll get a credit loaded to your UCard each month to buy covered OTC items. Unused credit expires at the end of each month. Covered items include brand name and generic OTC products like vitamins, pain relievers, bladder control pads and first aid products. The credit can't be used to buy tobacco or alcohol. **Home and bath safety devices** You can also use your OTC credit on covered home and bath safety devices like bathmats, grab bars and shower chairs. **Fitness equipment** You can use your OTC credit on covered fitness equipment like fitness mats, exercise machines or handheld weights, and wearable devices or activity trackers. **Support services** You can also use your OTC credit on covered in-home support services such as respite care, non-skilled in-home care, and weight management services. **Healthy food — Special Supplemental Benefits for the Chronically Ill (SSBCI)** If you qualify, healthy food and utitilies will be included as part of your OTC credit expiring monthly. Your eligibility for the healthy food and utilities is determined after you enroll in this plan. You must have at least one of the following chronic conditions to qualify: • Diabetes mellitus (type 1 or type 2) **This benefit is continued on the next page**	Monthly credit is $115 If you use an out-of-network provider for in-home services, respite care or weight management coaching, you pay 75% of the total cost. Combined with OTC credit amount Home shipped food, OTC products, home and bath safety devices and fitness equipment are available nationwide

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Covered Service	What you pay
Over-the-counter (OTC) credit (continued) • Cardiovascular disorders • Chronic heart failure • Chronic hypertension (chronic high blood pressure) • Chronic hyperlipidemia (chronic high cholesterol) • Autoimmune disorders • Cancer • Chronic alcohol use disorder and other substance use disorders (SUDs) • Chronic gastrointestinal disease • Chronic kidney disease (CKD) • Chronic lung disorders • Chronic and disabling mental health conditions • Dementia • HIV/AIDS • Immunodeficiency and immunosuppressive disorders • Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy • Neurologic disorders • Overweight, obesity and metabolic syndrome • Post-organ transplantation care • Severe hematologic disorders • Stroke • Conditions associated with cognitive impairment **This benefit is continued on the next page**	

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Covered Service	What you pay
Over-the-counter (OTC) credit (continued) • Conditions with functional challenges and require similar services Covered items include: • Healthy foods like fruits, vegetables, meat, seafood, dairy products, water and more. • Eligible utility bills like electricity, home heat like natural gas, water and home internet. The service address must match an address we have on file for you. You can use your credit at thousands of participating stores or place an order online. Home shipping is free and there is a $35 minimum to place an order. Taxes may apply. Visit the UCard Hub to learn more about using your benefit, check your balance, find covered products, locate participating stores and more.	
Partial hospitalization services and intensive outpatient services **Partial hospitalization** is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counseor's office. It can help keep you from having to stay in the hospital. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than the care you get in your doctor's or therapist's office but less intense than partial hospitalization.	**In-Network** $0 copayment each day for Medicare-covered benefits.†† **Out-of-Network** $0 copayment or 30% coinsurance each day for Medicare-covered benefits. You pay these amounts until you reach the out-of-pocket maximum.

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Covered Service	What you pay
Personal Emergency Response System (PERS) With a Personal Emergency Response System (PERS), help is a button press away. A PERS device can quickly connect you to the help you need, 24 hours a day in any situation. It's a lightweight, discreet button that can be worn on your wrist or as a pendant. It's also safe to wear in the shower or bath. Depending on the model you choose, it may even automatically detect falls. You must have a working landline or live in an area that has appropriate wireless coverage to get a PERS device. The cellular device works nationwide with the wireless network but does not require you to have a contract with the network.	$0

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Covered Service	What you pay
Physician/provider services, including doctor's office visits We pay for the following services: • medically necessary health care or surgery services given in places such as: • physician's office • certified ambulatory surgical center • hospital outpatient department • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your specialist, if your doctor orders them to find out whether you need treatment • 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: ◦ Outpatient mental health care ◦ Outpatient substance use disorder services ◦ You can access your virtual mental health visits even if you haven't had an in-person visit previously **This benefit is continued on the next page**	**In-Network** $0 copayment for services from a primary care physician or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a primary care physician's office (as allowed by Medicare). $0 copayment for services from a specialist or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a specialist's office (as allowed by Medicare).†† $0 copayment for each Medicare-covered exam.†† You'll 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.††

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Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) ◦ 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 in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a 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 aren't covered. • Additional Mental Health telehealth visits: ◦ Covered services include individual mental health services ◦ Virtual Mental Health Visits are mental health visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/ video capabilities. Visit **virtualvisitsmentalhealth.uhc.com** to learn more and schedule a virtual appointment. **This benefit is continued on the next page**	$0 copayment for primary care provider services or, in certain circumstances, nurse practitioner, physician's assistant or other non-physician health care professional services.†† $0 copayment for specialist physician services.†† **Out-of-Network** $0 copayment or 30% coinsurance for services from a primary care physician or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a primary care physician's office (as allowed by Medicare). *You pay these amounts until you reach the out-of-pocket maximum.* $0 copayment or 30% coinsurance for services from a specialist or under certain circumstances, treatment by a nurse practitioner, physician's assistant or other non-physician health care professional in a specialist's office (as allowed by Medicare). You pay these amounts until you reach the out-of-pocket maximum.

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Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ◦ Virtual Medical Visits are medical visits delivered to you outside of medical facilities by network providers that have appropriate online technology and live audio/video capabilities to conduct the visit. ◦ Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment. ◦ Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare. • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder • 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 **This benefit is continued on the next page**	$0 copayment for each Medicare-covered exam. *You pay these amounts until you reach the out-of-pocket maximum.* *You'll pay the cost-sharing that applies to specialist services (as described under "Physician/practitioner services, including doctor's office visits" above).* *You'll pay the cost-sharing that applies to primary care provider services or specialist physician services (as applied in an office setting, described above in this section of the benefit chart) depending on the type of physician that provides the services.*

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Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) ◦ you have an in-person visit every 12 months while receiving these telehealth services ◦ exceptions can be made to the above for certain circumstances • telehealth services for mental health visits provided by rural health clinics and federally qualified health centers. • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if** ◦ you're not a new patient **and** ◦ the check-in isn't related to an office visit in the past 7 days **and** ◦ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: ◦ you're not a new patient and ◦ the evaluation isn't related to an office visit in the past 7 days **and** ◦ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery **This benefit is continued on the next page**	

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Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) • Medicare-covered remote monitoring services • Monitoring services in a physician's office or outpatient hospital setting if you're taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as "Coumadin Clinic" services) • Medically-necessary medical or surgical services that are covered benefits and are furnished by a physician in your home or a nursing home in which you reside • Certain telehealth services, including: ◦ Additional Virtual Medical Visits: • Urgently Needed Services • Primary Care Provider • Specialist • Other Health Care Professionals • Other types of Virtual Medical Visits: ◦ Cardiac Rehabilitation Services ◦ Intensive Cardiac Rehabilitation Services ◦ Outpatient Rehabilitation Services ◦ Physical Therapy and Speech-Language Therapy Please note that virtual visits may require video-enabled smartphone or other device. Not for use in emergencies. Not all network providers offer virtual care.	

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Covered Service	What you pay
Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes	**In-Network** $0 copayment for each Medicare-covered visit in an office or home setting.†† For services rendered in an outpatient hospital setting, such as surgery, please refer to Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers. **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered visit in an office or home setting. You pay these amounts until you reach the out-of-pocket maximum.
Podiatry Services (Additional Routine Foot Care) We cover 4 in and out-of-network routine foot care visits every year. This benefit is in addition to the Medicare covered podiatry services benefit listed above. Covered services include treatment of the foot which is generally considered preventive, i.e., cutting or removal of corns, warts, calluses or nails.	**In-Network** $0 copayment for each routine visit. **Out-of-Network** 30% coinsurance for each routine visit.*

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	**In-network** There is no coinsurance, copayment, or deductible for the PrEP benefit. **Out-of-network** $0 copayment or 40% coinsurance for members eligible for the PrEP benefit. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Prescription drugs (Outpatient) These drugs are covered under Part B of Original Medicare. Enrollees of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you're getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Antigens (for allergy shots) • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases **This benefit is continued on the next page**	$0, Medicare-covered Part B drug.††

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Prescription drugs (Outpatient) (continued) • Chemotherapy Drugs, and the Administration of chemotherapy You or your doctor may need to provide more information about how a Medicare Part B prescription drug is used in order to determine coverage. If you're prescribed a new medication or haven't 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're not right for you, you or your doctor can ask the plan to cover this drug. (For more information, see **Chapter 9**, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).) Please contact Enrollee Services for more information. We also cover some vaccines under our Part B and Part D prescription drug benefit. **Chapter 5** explains the Part D and DC Medicaid prescription drug benefit, including rules you must follow to have prescriptions covered.	

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Prostate cancer screening exams For men age 50 and over, we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	**In-Network** There is no coinsurance, copayment, or deductible for each Medicare-covered digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test. **Out-of-Network** $0 copayment or 40% coinsurance for each Medicare-covered digital rectal exam. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 40% 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.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies Prosthetic devices replace all or part of a body part or function. These include but aren't limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.	**In-Network** $0 copayment for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices and related supplies.†† **Out-of-Network** $0 copayment or 20% coinsurance for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices and related supplies. You pay these amounts until you reach the out-of-pocket maximum.
Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD. 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.	**In-Network** $0 copayment for each Medicare-covered pulmonary rehabilitative vist.†† **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered pulmonary rehabilitative visit. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945–1965. If you were born between 1945–1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	**In-network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus. **Out-of-network** 40% coinsurance for members eligible for the Medicare-covered screening for the Hepatitis C Virus.
Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STI's and counseling for STI's preventive benefit. **Out-of-Network** $0 copayment or 40% coinsurance for the Medicare-covered screening for STI's and counseling for STI's preventive benefit. You pay these until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to **Chapter 12**. We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it's medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration. Coverage begins with the first pint of blood that you need. • medical and surgical supplies given by SNFs • lab tests given by SNFs • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You usually get SNF care from network facilities. Under certain conditions, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered SNF stay, up to 100 days.†† You're covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. **Out-of-Network** You pay a $0 copayment each day for days 1–100, or the Original Medicare cost sharing amount for 2026, which is: $0 copayment each day for Medicare-covered days 1–20 $217 copayment each day for Medicare-covered days 21–100.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	$0 copayment each day for Medicare-covered days 1–20 $209.50 copayment each day for Medicarecovered days 21–100. You pay these amounts until you reach the out-of-pocket maximum. You're covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Smoking and tobacco use cessation Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • are competent and alert during counseling • a qualified physician or other Medicare-recognized practitioner provides counseling We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-Network** $0 copayment or 40% coinsurance for the Medicare-covered smoking and tobacco use cessation preventive benefits. You must pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD). Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	**In-Network** $0 copayment for each Medicare-covered supervised exercise therapy (SET) visit.†† **Out-of-Network** $0 copayment or 30% coinsurance for the Medicare-covered exercise therapy (SET) visit. You pay these amounts until you reach the out-of-pocket maximum.
Transportation services You're eligible for unlimited rides to approved locations under your Medicaid benefit. This benefit covers rides to for routine and urgent provider appointments, follow-up visits, hospital discharges and urgent care services.	$0

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • an unforeseen illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider beause given your time, place, or circumstances, it isn't possible, or it's unreasonable, to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency). Worldwide coverage for 'urgently needed services' when medical services are needed right away because of an illness, injury, or condition that you didn't expect or anticipate, and you can't wait until you're back in our plan's service area to obtain services. Services provided by a dentist aren't covered.	$0 copayment for each visit. $0 copayment for worldwide coverage of urgently needed services received outside of the United States. Please see **Chapter 7, Section A** for expense reimbursement for worldwide services.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Vision care We pay for: • one routine eye exam (eye refraction) each year • one pair of eyeglasses every 2 years unless: ◦ a change of at least+/- 0.50 diopters from the prior prescription; ◦ a change of at least= 0.75 sphere or- 0.50 sphere, 0.50 cylinder, ~prism diopter vertical, or 3 prism diopter lateral; ◦ there has been a major change in visual acuity documented by a licensed optometrist; ◦ the frames or lenses have been lost or broken beyond repair; **or** ◦ a separate pair of readers is preferred to bifocals. • contacts, limited to two boxes (one per eye) in a 6 month period All medically necessary repairs and replacements are covered, including eyeglasses, any vision device/lens, or repairs/replacements to the actual eye. We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes **This benefit is continued on the next page**	**In-Network** $0 copayment for each Medicare-covered exam.†† $0 copayment for Medicare-covered glaucoma screening. $0 copayment for Medicare-covered eye exams to evaluate for eye disease.†† $0 copayment for one pair of Medicaid-covered standard glasses or contact lenses after cataract surgery. **Out-of-Network** $0 copayment or 30% coinsurance for each Medicare-covered exam. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 40% coinsurance for Medicare-covered glaucoma screening. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 30% coinsurance for Medicare-covered eye exams to evaluate for eye disease. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
Vision care (continued) • African-Americans who are age 50 and over • Hispanic Americans who are 65 or over For people with diabetes, we pay for screening or diabetic retinopathy once per year. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. Covered eyeglasses after cataract surgery includes stand frames and lenses as defined by Medicare; any updates aren't covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating).	$0 copayment or 40% coinsurance for one pair of Medicaid-covered standard glasses or contact lenses after cataract surgery. You pay these amounts until you reach the out-of-pocket maximum.

Some Medicare-covered services show a cost share range. If you're a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

Covered Service	What you pay
“Welcome to Medicare” preventive visit We cover the one-time “Welcome to Medicare” preventive visit. The visit includes: • a review of your health, • education and counseling about preventive services you need (including screenings and shots (or vaccines)), **and** • referrals for other care if you need it. Doesn't include lab tests, radiological diagnostic tests or non-radiological diagnostic tests. Additional cost share may apply to any lab or diagnostic testing performed during your visit, as described for each separate service in this Medical Benefits Chart. **Note:** We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.	**In-Network** There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit. There is no coinsurance, copayment, or deductible for a one-time Medicare-covered EKG screening if ordered as a result of your “Welcome to Medicare” preventive visit. Please refer to outpatient diagnostic tests and therapeutic services and supplies for other EKG’s. **Out-of-Network** $0 copayment or 40% coinsurance for the “Welcome to Medicare” preventive visit. You pay these amounts until you reach the out-of-pocket maximum. $0 copayment or 40% coinsurance for a onetime Medicare-covered EKG screening if ordered as a result of your “Welcome to Medicare” preventive visit. Please refer to Outpatient diagnostic tests and therapeutic services and supplies for other EKG’s. You pay these amounts until you reach the out-of-pocket maximum.

*Covered services that don’t count toward your maximum out-of-pocket amount.

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

Some Medicare-covered services show a cost share range. If you’re a Qualified Medicare Beneficiary (QMB) or have full Medicaid benefits and your provider accepts Medicaid, you pay a $0 cost share for Medicare-covered services. See the Medicare cost sharing section at the beginning of the chart for details on when cost sharing may apply.

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

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

To be eligible for the EPD Waiver, you must:

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

D2. The EPD Waiver offers a combination of in-home or community-based support services, which include:

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

E. Benefits covered outside of our plan

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

E1. Services Provided by DC Department of Behavioral Health (DBH) Certified Providers

Some behavioral health services aren't covered by this program, but are available to you through the DC Department of Behavioral Health certified providers, including:

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

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

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

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

We don't pay for excluded medical benefits listed in this section (or anywhere else in this *Enrollee Handbook*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won't pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Enrollee Handbook*.

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

- services considered not “reasonable and medically necessary”, according Medicare and DC Medicaid standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of your *Enrollee Handbook* for more information on clinical research studies. Experimental treatment and items are those that aren’t generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- fees charged by your immediate relatives or members of your household
- meals delivered to your home
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it’s needed because of an accidental injury or to improve a part of the body that isn’t shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we’ll reimburse the veteran for the difference. You’re still responsible for your cost-sharing amounts.
- Equipment or supplies that condition the air and other primarily non-medical equipment
- Immunizations for foreign travel purposes
- Experimental drugs

- For transplants: items not covered include but aren't limited to the below.
- For transportation:
  - Vehicle rental, purchase, or maintenance/repairs
  - Auto clubs (roadside assistance)
  - Gas
  - Travel by air or ground ambulance (may be covered under your medical benefit).
  - Air or ground travel not related to medical appointments
  - Premium, business class or first class travel
  - 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, snacks, food or beverages

Eligible travel and lodging expenses when you're receiving covered transplant services at a location that is in the plan's transplant network for the type of transplant you need but that is outside the normal community pattern of care from your home include:

Transportation: Vehicle mileage, economy/coach airfare, taxi fares, or rideshare services. Eligible transportation services aren't subject to a daily limit amount.

Lodging: Costs for lodging or places to stay such as hotels, motels or short-term housing. You can be reimbursed for eligible lodging costs up to $125 per day total.

Because Medicare-approved transplant centers aren't available for every type of transplant in every state, your local community pattern of care for transplants may require that you travel some distance in order to receive your transplant. Travel and lodging expenses aren't reimbursable if you receive a transplant at any location in either your state of residence or a state adjacent to your state of residence, or you receive your transplant in the state with the nearest transplant center to you (for your required transplant type) regardless of distance.

Submission of the transplant travel reimbursement form must occur within 365 days of the date the travel or lodging expense was incurred.

Chapter 5: Getting your outpatient prescription drugs

Introduction

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

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

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

Rules for our plan's outpatient drug coverage

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

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

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

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

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "**Drug List**" for short. (Refer to **Section B** of this chapter.)

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

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug.

Your drug may require approval before we'll cover it. Refer to **Section C** in this chapter.

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A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

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

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

A2. Using your UCard when you fill a prescription

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

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

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

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

A3. What to do if you change your network pharmacy

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

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

A4. What to do if your pharmacy leaves the network

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

To find a new network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Enrollee Services or your care navigator.

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.

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

To find a specialized pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website **myuhc.com/CommunityPlan**, or contact Enrollee Services or your care coordinator.

A6. Using mail-order services to get your drugs

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

Filling prescriptions by mail

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

Usually, a mail-order prescription arrives within ten business days. However, sometimes your mail-order may be delayed. If your mail-order is delayed, please follow these steps:

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

Mail-order processes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A7. Getting a long-term supply of drugs

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

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

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

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. In these cases, check with your care navigator or Enrollee Services first to find out if there's a network pharmacy nearby.

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

- **Prescriptions for a medical emergency**

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

- If you're unable to obtain a covered drug in a timely manner within the service area because a network pharmacy that provides 24-hour service isn't within reasonable driving distance.
- If you're trying to fill a prescription drug not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- If you need a prescription while a patient in an emergency department, provider based clinic, outpatient surgery, or other outpatient setting.
- Any prescriptions filled outside of the United States aren't covered.

If you must use an out-of-network pharmacy, you'll 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. (Go to **Chapter 7, Section B** for information on how to ask the plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost when you get your prescription. You can ask us to pay you back for our share of the cost. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at a network pharmacy.

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

B. Our plan's Drug List

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

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

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

B1. Drugs on our Drug List

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

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

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

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name or original biological products 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.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the **Drug List**.

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

B2. How to find a drug on our Drug List

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

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

B3. Drugs not on our Drug List

We don't cover all drugs.

- Some drugs aren't on our **Drug List** because the law doesn't allow us to cover those drugs
- In other cases, we decided not to include a drug on our **Drug List**.

- In some cases, you may be able to get a drug that isn't on our **Drug List**. For more information refer to **Chapter 9**.

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

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and DC Medicaid drugs) can't pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits.
2. Our plan can't cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

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

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

B4. Drug List cost-sharing tiers

Every drug on our **Drug List** is one of 5 tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug.

Tier 1 – Preferred Generic – Lower-cost, commonly used generic drugs.

Tier 2 – Generic – Many generic drugs.

Tier 3 – Preferred Brand – Many common brand name drugs, called preferred brands, and some higher-cost generic drugs.

Tier 3 – Covered Insulin Drugs – Covered insulins 25%, up to $35 for each 1-month supply until the catastrophic stage.[1]

Tier 4 – Non-preferred Drug – Non-preferred generic and non-preferred brand name drugs.

Tier 5 – Specialty Tier – Unique and/or very high-cost brand and generic drugs.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

[1]You pay no more than 25% of the total drug cost or a $35 copayment, whichever is lower, for each 1-month supply of Part D covered insulin drugs, even if you haven't paid your deductible, until you reach the Catastrophic Coverage stage where you pay $0.

To find out which cost-sharing tier your drug is in, look for the drug on our **Drug List**.

Chapter 6 of this *Enrollee Handbook* tells the amount you pay for drugs in each tier.

C. Limits on some drugs

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

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 provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

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

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

What's a compounded drug?

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

Does my Part D plan cover compounded drugs?

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

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

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

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

Compound Type	Medicare Coverage
Compound containing a Part B eligible ingredient	Compound is covered only by Part B
Compound containing all ingredients eligible for Part D coverage and all ingredients are approved for use in a compound	Compound may be covered by Part D upon approved coverage determination
Compound containing ingredients eligible for Part D coverage and approved for use in a compound, and ingredients excluded from Part D coverage (for example, over the counter drugs, etc.)	Compound may be covered by Part D upon approved coverage determination. However, the ingredients excluded from Part D coverage won't be covered and you're 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 isn't covered by Part D. You're responsible for the entire cost

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

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

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

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

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

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

- We usually don't pay for the brand name drug or original biological product when there is an available generic version.
- However, if your provider told us the medical reason that the generic drug or interchangeable biosimilar won't work for you or wrote "No substitutions" on your prescription for a brand name drug or original biological product or told us the medical reason that the generic drug interchangeable biosimilar, or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.

2. **Getting plan approval in advance**

   For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get approval, we may not cover the drug. Call Enrollee Services at the number at the bottom of the page or on our website at **MyUHC.com/CommunityPlan** for more information about prior authorization.

3. **Trying a different drug first**

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

   If Drug A does **not** work for you, then we cover Drug B. This is called step therapy. Call Enrollee Services at the number at the bottom of the page or on our website at **MyUHC.com/CommunityPlan** for more information about step therapy.

4. **Quantity limits**

   For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug we might limit how much of a drug you can get each time you fill your prescription.

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

D. Reasons your drug might not be covered

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

- Our plan doesn't cover the drug you want to take. The drug may not be on our **Drug List**. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.

- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

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

D1. Getting a temporary supply

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

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

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

- We cover one 30-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
- There may be unplanned transitions such as hospital discharges (including psychiatric hospitals) or level of care changes (i.e., changing long-term care facilities, exiting and entering a long-term care facility, ending Part A coverage within a skilled nursing facility, or ending hospice coverage and reverting to Medicare coverage) that can occur anytime. If you're prescribed a drug that isn't on our **Drug List** or your ability to get your drugs is restricted in some way, you're 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.

D2. Asking for a temporary supply

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

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

- Change to another drug.

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

  OR

- Ask for an exception.

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

D3. Asking for an exception

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

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

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

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

E. Coverage changes for your drugs

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

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

We must follow Medicare requirements before we change our plan's **Drug List**. For more information on these drug rules, refer to **Section C**.

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

- a new, cheaper drug comes on the market that works as well as a drug on our **Drug List** now, **or**
- we learn that a drug isn't safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you're taking?

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

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

Changes we may make to the Drug List that affect you during the current plan year

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

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

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

  - We may not tell you before we make this change, but we send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of your **Member Handbook** for more information on exceptions.

Removing unsafe drugs and other drugs that are taken off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our **Drug List**. If you're taking the drug, we send you a notice after we make the change, and can work with you to find another drug for your condition.

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

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

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

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

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

Changes to the Drug List that don't affect you during this plan year

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year**.

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

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We'll not tell you above these types of changes directly during the current year. You'll 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 that will impact you during the next plan year.

F. Drug coverage in special cases

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

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

F2. In a long-term care facility

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

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

F3. In a Medicare-certified hospice program

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

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

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

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

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

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

- may not be needed because you take another similar drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you're or may be allergic to
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

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

G2. Programs to help you manage your drugs

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

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

Then, they will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

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

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

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

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

G3. Drug management program (DMP) to help enrollees safely use opioid medications

We have a program that helps make sure enrollees 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 include:

- Requiring you to get all prescriptions for opioid or benzodiazepine medications from 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'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescriber or pharmacies you prefer to use and any 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'll send you another letter that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to medications, we automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of your *Enrollee Handbook*.)

The DMP may not apply to you if you:

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

Chapter 6: What you pay for your Medicare and DC Medicaid prescription drugs

Introduction

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

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

Because you're eligible for DC Medicaid you get Extra Help from Medicare to help pay for your Medicare Part D prescription drugs. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Enrollee Services and ask for the "LIS Rider."

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

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

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

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

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

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A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your drug costs and the payments you make when two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

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

- **Information for the month.** The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives.** When applicable, information about other available drugs with lower cost-sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

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

B. How to keep track of your drug costs

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

1. **Use your UCard.**

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

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

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

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

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

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

3. **Send us information about payments others make for you.**

   Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

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

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

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

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at UHC Dual Choice DC-Y2 (PPO D-SNP) Enrollee Services. You can also find answers to many questions on our website: **MyUHC.com/CommunityPlan**.

What about possible fraud?

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

- Call us at UHC Dual Choice DC-Y2 (PPO D-SNP) Enrollee Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free.
- You may also call the DC Department of Health Care Finance's Fraud Hotline at 1-877-632-2873 to report suspected Medicaid fraud.

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

C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay for each prescription depends on which stage you're in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, we pay all of the costs of your drugs through December 31, 2026. You begin this stage when you've paid a certain amount of out-of-pocket costs.

C1. Our plan has 5 cost sharing tiers

Every drug on the plan's **Drug List** is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

Tier 1 – Preferred Generic – Lower-cost, commonly used generic drugs.

Tier 2 – Generic – Many generic drugs.

Tier 3 – Preferred Brand – Many common brand name drugs, called preferred brands, and some higher-cost generic drugs.

Tier 3 – Covered Insulin Drugs – Covered Insulins 25%, up to $35 for each 1-month supply until the catastrophic stage.

Tier 4 – Non-preferred Drug – Non-preferred generic and non-preferred brand name drugs.

Tier 5 – Specialty Tier – Unique and/or very high-cost brand and generic drugs.

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

C2. Your pharmacy choices

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

- a network pharmacy, **or**
- an out-of-network pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Enrollee Handbook* to find out when we do that.
- Our plan's mail-order pharmacy.

Refer to **Chapter 9** of this *Enrollee Handbook* to learn about how to file an appeal if you're told a drug won't be covered. To learn more about these pharmacy choices, refer to **Chapter 5** of this *Enrollee Handbook* and our *Provider and Pharmacy Directory*.

C3. Getting a long-term supply of a drug

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

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

C4. What you pay

You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Enrollee Services to find out how much your copay is for any covered drug.

For Members that Qualify for "Extra Help":

For generic drugs (including drugs treated as generic) either:

- $0
- $1.60
- $5.10

For all other drugs

- $0
- $4.90
- $12.65

You'll pay the following for your covered prescription drugs if you DON'T qualify for "Extra Help" from Medicare to help pay for your prescription drug costs:

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

Mail-order cost sharing for Tiers 1, 2, and 3 are limited to a 100 day long-term supply. See the long-term supply chart below for details on what you pay.

Some medications are packaged by the manufacturer in amounts that exceed a 1-month supply and can't be split. If that's the case, you may be charged more than one copayment or coinsurance for a single prescription.

Your share of the cost when you get a one-month or long-term supply of a covered drug from:

	A Network Pharmacy A one-month or up to a 30-day supply	**A Network Long-Term Care Pharmacy** Up to a 31-day supply	**An Out-of-Network Pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this **Evidence of Coverage** for details.
Cost-sharing Tier 1 Preferred Generic	$0	$0	$0
Cost-sharing Tier 2 Generic	25% coinsurance	25% coinsurance	25% coinsurance
Cost-sharing Tier 3 Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance
Cost-sharing Tier 3 Covered Insulin Drugs **Note:** You'll 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	25% coinsurance, up to $35 copayment	25% coinsurance, up to $35 copayment	25% coinsurance, up to $35 copayment
Cost-sharing Tier 4 Non-Preferred Drug Limited to a 30-day supply	25% coinsurance	25% coinsurance	25% coinsurance
Cost-sharing Tier 5 Specialty Tier Limited to a 30-day supply	25% coinsurance	25% coinsurance	25% coinsurance

For more information about which pharmacies can give you long-term supplies, refer to our plan's *Provider and Pharmacy Directory*.

D. Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, we pay a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on the cost-sharing tier the drug is in and where you get it.

Cost-sharing tiers are groups of drugs with the same copay. Every drug on our plan's **Drug List** is in one of five cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our **Drug List**.

Tier 1 – Preferred Generic – Lower-cost, commonly used generic drugs.

Tier 2 – Generic – Many generic drugs.

Tier 3 – Preferred Brand – Many common brand name drugs, called preferred brands, and some higher-cost generic drugs.

Tier 3 – Covered Insulin Drugs – Covered Insulins 25%, up to $35 for each 1-month supply until the catastrophic stage.

Tier 4 – Non-preferred Drug – Non-preferred generic and non-preferred brand name drugs.

Tier 5 – Specialty Tier – Unique and/or very high-cost brand and generic drugs.

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

D1. Your pharmacy choices

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

- A network retail pharmacy **or**
- A network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- An out-of-network pharmacy.
- Our plan's mail-order pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Enrollee Handbook* to find out when we do that.

To learn more about these choices, refer to **Chapter 5** of this *Enrollee Handbook* and to our *Provider and Pharmacy Directory*.

D2. Getting a long-term supply of a drug

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

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

If you qualify for "Extra Help" from Medicare to help pay for your prescription drug costs, your costs for your Medicare Part D prescription drug will be lower than the amounts listed in the chart below. If you have Medicare and DC Medicaid you automatically qualify for Extra Help. Members with the lowest income and resources are eligible for the most Extra Help. (Please see your Low Income Subsidy Rider for more information about your actual drug costs.)

For Members that Qualify for "Extra Help":

For generic drugs (including drugs treated as generic) either:

- $0
- $1.60
- $5.10

For all other drugs

- $0
- $4.90
- $12.65

You'll pay the following for your covered prescription drugs if you DON'T qualify for "Extra Help" from Medicare to help pay for your prescription drug costs:

Some medications are packaged by the manufacturer in amounts that exceed a 3-month supply and can't be split. If that's the case, you may be charged more than one copayment or coinsurance for a single prescription.

D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Enrollee Services to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month or long-term supply of a covered drug from:

	A Network Pharmacy A one-month or up to a 100-day supply	**Our Plan's Mail-Order Service** A one-month or up to a 100-day supply **Note:** Our plan's mail order isn't available for drugs (up to a 30-day supply) in Tier 1, Tier 2, or Tier 3.
Cost-sharing Tier 1 Preferred Generic	$0	$0
Cost-sharing Tier 2 Generic	25% coinsurance	25% coinsurance
Cost-sharing Tier 3 Preferred Brand	25% coinsurance	25% coinsurance
Cost-sharing Tier 3 Covered Insulin Drugs **Note:** You'll 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	25% coinsurance, up to $105 copayment	25% coinsurance, up to $105 copayment
Cost-sharing Tier 4 Non-Preferred Drug Limited to a 30-day supply	A long-term supply isn't available for drugs in Tier 4.	A long-term supply isn't available for drugs in Tier 4.
Cost-sharing Tier 5 Specialty Tier Limited to a 30-day supply	A long-term supply isn't available for drugs in Tier 5.	A long-term supply isn't available for drugs in Tier 5.

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$2,100**. At that point, the Catastrophic Coverage Stage begins. We cover all our drug costs from then until the end of the year.

Your EOB helps you keep track of how much you've paid for your drugs during the year. We let you know if you reach the $2,100 limit. Many people don't reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $2,100 for your drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

F. Your drug costs if your doctor prescribes less than a full month's supply

In some cases, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you're trying a drug for the first time).
- If your doctor agrees, you don't pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. We calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days' supply of the drug, your payment is less than $.05 per day multiplied by 7 days, for a total payment less than $0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
  - Better plan when to refill your drugs,
  - Coordinate refills with other drugs you take, and
  - Take fewer trips to the pharmacy.

G. What you pay for Part D vaccines

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

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

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

G1. What you need to know before you get a vaccination

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

- We can tell you about how our plan covers your vaccine
- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of your *Enrollee Handbook*.

Chapter 7: Asking us to pay a bill you got for covered services or drugs

Introduction

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

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A. Asking us to pay for your services or drugs

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

We don't allow UHC Dual Choice DC-Y2 (PPO D-SNP) providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

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

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

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

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

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

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back for our share of the cost. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
     - If the provider should be paid, we'll pay the provider directly.
     - If you already paid more than your share of the cost for the Medicare service, we'll figure out how much you owed and pay you back for our share of the cost.

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

Network providers must always bill us. It's important to show your UCard when you get any services or prescriptions. But sometimes they make mistakes, and ask you to pay for your services or more than your share of the costs. **Call Enrollee Services** or your care navigator at the number at the bottom of this page **if you get any bills**.

- As a plan enrollee, you only pay the copay when you get services we cover. We don't allow providers to bill you more than this amount. This is true even if we pay the provider less than the provider charged for a service. Even if we decide not to pay for some charges, you still don't pay them.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We'll contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, but feel you paid too much, send us the bill and proof of any payment you made. We'll pay you back for your covered services or for the difference between the amount you paid and the amount you owed under our plan.

3. **If you're retroactively enrolled in our plan**

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

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

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

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

   - In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
   - Refer to **Chapter 5** of your *Enrollee Handbook* to learn more about out-of-network pharmacies.
   - 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 prescription cost because you don't have your UCard with you**

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

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

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

   - The drug may not be on our *List of Covered Drugs* **(Drug List)** on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
     - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Enrollee Handbook*).
     - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your *Enrollee Handbook*).
   - Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

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

   Important: If you're admitted to a hospital following a medical emergency while traveling outside the United States, call Customer Service immediately using the number on your health plan ID card. This ensures timely coordination of care and access to support.

   You'll pay the full cost of emergency services received outside of the United States at the time you receive services. To receive reimbursement from us, you must do the following:· Pay your bill at the time it is received. We will reimburse you for the difference between the amount of your bill and your cost share for the services as outlined in Chapter 4 and the Exclusions sections of this document.

   - Save all of your receipts and send us copies when you ask us to reimburse you. In some situations, we may need to get more information from you or the provider who rendered services to you in order to pay you back for our share of the cost.
   - If you're being asked to pay your bill for worldwide emergency services and are unable to make the payment, please call Customer Service for additional assistance and we may be able to work directly with the rendering provider to help coordinate payment for covered services on your behalf. You must request payment for foreign services directly from us, and you or the rendering provider must submit all documentation directly to us.
   - Payment requests from intermediaries, claims management companies or third-party billers that are separate from the rendering provider aren't reimbursable. We never provide forms to foreign providers, claims management companies, or third-party billers that would require your signature and/or a deposit or payment by you in order for you to receive reimbursement from us. In some countries, you may be asked to pay a deposit or sign forms, and the provider will represent that they will collect the rest from us directly. However, forms that a foreign provider, claims management company, or third-party biller submits to us on your behalf won't be reimbursed by us, even if those forms include the UHC name or logo. We will only consider requests for reimbursement for medical services

that you receive from a foreign provider that you submit to us directly. This allows us to confirm that you received the services, and that you're being reimbursed the same amount that you were billed or paid at the time the service was rendered.

- If you receive any services in a foreign country that aren't covered worldwide emergency or urgently needed services as described in this Evidence of Coverage, you're fully responsible for payment for those services. Neither the plan nor Medicare will pay for services received outside of the United States that aren't explicitly described as covered in this Evidence of Coverage.
- You must request reimbursement from the Health Plan within 12 months from the date services are received. You must provide the following documentation with your submission:
  1. An itemized bill from the facility including the hospital's name, your's name, dates of stay, a list of charges, a brief description of each charge, and a total.
  2. A receipt/proof of payment showing that the amount on the bill was paid. Acceptable proofs of payment are credit card receipt, canceled check or bank statement. For cash payments, a provider's itemized invoice showing cash payment was made and detailing any remaining balance is acceptable.
  3. A copy of the medical record or documentation describing the medical situation and treatment course.

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

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

B. Sending us a request for payment

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

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

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

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

UnitedHealthcare Dual Choice (PPO D-SNP)
P.O. Box 5280
Kingston, NY 12402

C. Coverage decisions

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

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay our share of the cost for it. If you already paid for the service or drug, we'll mail you a check for our share of the cost. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

Chapter 3 of your *Enrollee Handbook* explains the rules for getting your services covered. **Chapter 5** of your *Enrollee Handbook* explains the rules for getting your Medicare Part D drugs covered.

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

D. Appeals

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

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

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

Chapter 8: Your rights and responsibilities

Introduction

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

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

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

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

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

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

We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that's accessible and appropriate for you.

- To get information from us in a way that works for you, please call Enrollee Services or your care navigator.
- To keep your information as a standing request for future mailings and communications please reach out to your care navigator or call Enrollee Services.
- To change your standing request for preferred language and/or format please reach out to your care manager or call Enrollee Services.

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

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

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

You have rights as an enrollee of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Enrollee Handbook*.
  - Call your care navigator or Enrollee Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- **How to Receive Care After Hours**
  - If you need to talk to or see your Primary Care Provider after the office has closed for the day, call your Primary Care Provider's office. When the on-call physician returns your call he or she will advise you on how to proceed.
  - If you think that you're not getting your medical care or Part D drugs within a reasonable amount of time, **Chapter 10** tells what you can do.
- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that isn't your PCP. We **don't** require you to use network providers.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that's urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Enrollee Handbook*.
- You have the right to know that when you talk with your doctors and other providers it's private.
- You have the right to have an illness or treatment explained to you in a language you can understand.
- You have the right to participate in decisions about your care, including the right to refuse treatment.
- You have the right to receive a full, clear, and understandable explanation of treatment options and risks of each option so you can make an informed decision.
- You have the right to refuse treatment or care.
- You have the right to see and receive a copy of your medical records and request an amendment or change, if incorrect.

- You have the right to be free from any form of restraints or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- You have the right to receive access to health care services that are available and accessible to you in a timely manner.
- You have the right to choose an eligible PCP/PDP from within UHC Dual Choice DC-Y2 (PPO D-SNP)'s network and to change your PCP/PDP.
- You have the right to make a grievance about the care provided to you and receive an answer.
- You have the right to request an appeal or a fair hearing if you believe UHC Dual Choice DC-Y2 (PPO D-SNP)'s was wrong in denying, reducing, or stopping a service or item.
- You have the right to receive Family Planning Services and supplies from the provider of your choice.
- You have the right to obtain medical care without unnecessary delay.
- You have the right to receive a second opinion from a qualified health care professional within the network, or, if necessary, to obtain one outside the network, at no cost to you.
- You have the right to receive information on Advance Directives and choose not to have or continue any life sustaining treatment.
- You have the right to receive a copy of UHC Dual Choice DC-Y2 (PPO D-SNP)'s **Provider Directory**.
- You have the right to continue treatment you're currently receiving until you have a new treatment plan.
- You have the right to receive interpretation and translation services free of charge.
- You have the right to refuse oral interpretation services.
- You have the right to receive transportation services to approved locations under your Medicaid benefit free of charge.
- You have the right to get an explanation of prior authorization procedures.
- You have the right to receive information about UHC Dual Choice DC-Y2 (PPO D-SNP)'s financial condition and any special ways we pay our doctors.
- You have the right to obtain summaries of customer satisfaction surveys.
- You have the right to receive UHC Dual Choice DC-Y2 (PPO D-SNP)'s "Dispense as Written" policy for prescription drugs.
- You have the right to receive a list of all covered drugs.
- You have the right to be treated with respect and due consideration for your dignity and right to privacy.

- You have the right to receive information about the organization, its services, its practitioners and providers and enrollee rights and responsibilities.
- You have the right to make recommendations regarding the organization's enrollee rights and responsibilities policy.

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

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

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

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

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

C1. How we protect your PHI

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

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

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

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare and DC Medicaid your PHI including information about your Medicare Part D drugs. If Medicare or DC Medicaid releases your PHI for research or other uses, they do it according to federal laws.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.: We may charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.

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

HEALTH PLAN NOTICES 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

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

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

By law, we must follow the terms of our current notice.

HI is information about your health or medical services. We have the right to make changes to this notice of privacy practices. If we make important changes, we'll notify you by mail or e-mail. We'll also post the new notice on our website. Any changes to the notice will apply to all HI we have. We'll notify you of a breach of your HI.

How We Collect, Use, and Share Your Information

We collect, use and share your HI with:

- You or your legal or personal representative.
- Certain Government agencies. To check to make sure we are following privacy laws.

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

- **For Payment.** To process payments and pay claims. For example, we may tell a doctor whether we'll pay for certain medical procedures and what percentage of the bill may be covered.
- **For Treatment or Managing Care.** To help with your care. For example, we may share your HI with a hospital you're in, to help them provide medical care to you.
- **For Health Care Operations.** To run our business. For example, we may talk to your doctor to tell him or her about a special disease management or wellness program available to you. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** If you receive health insurance through your employer, we may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.
- **For Underwriting Purposes.** To make health insurance underwriting decisions. We won't use your genetic information for underwriting purposes.

- **For Reminders on Benefits or Care.** We may send reminders about appointments you have and information about your health benefits.
- **For Communications to You.** We may contact you about your health insurance benefits, healthcare or payments.

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

- **As Required by Law.** To follow the laws that apply to us.
- **To Persons Involved with Your Care.** A family member or other person that helps with your medical care or pays for your care. This also may be to a family member in an emergency. This may happen if you're unable to tell us if we can share your HI or not. If you're unable to tell us what you want, we'll use our best judgment. If allowed, after you pass away, we may share HI with family members or friends who helped with your care or paid for your care.
- **For Public Health Activities.** For example, to prevent diseases from spreading or to report problems with products or medicines.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with certain entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings**, for example, to answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** To public health agencies or law enforcement, for example, in an emergency or disaster.
- **For Government Functions.** For military and veteran use, national security, or certain protection services.
- **For Workers' Compensation.** If you were hurt at work or to comply with employment laws.
- **For Research.** For example, to study a disease or medical condition. We also may use HI to help prepare a research study.
- **To Give Information on Decedents.** For example, to a coroner or medical examiner who may help identify the person who died, why they died, or to meet certain laws. We also may give HI to funeral directors.
- **For Organ Transplant.** For example, to help get, store or transplant organs, eyes or tissues.
- **To Correctional Institutions or Law Enforcement.** For persons in custody, for example: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates.** To give you services, if needed. These are companies that provide services to us. They agree to protect your HI.

- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below. We'll follow stricter laws that apply.

  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'll only use or share your HI as described in this notice or with your written consent. We'll get your written consent to share psychotherapy notes about you, except in certain cases allowed by law. We'll get your written consent to sell your HI to other people. We'll get your written consent to use your HI in certain marketing mailings. If you give us your consent, you may take it back. To find out how, call the phone number on your health insurance ID card.

Your Rights

You have the following rights for your medical information.

- **To ask us to limit** our use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others that help with your care or pay for your care. We may allow your dependents to ask for limits. **We'll try to honor your request, but we don't have to do so.** Your request to limit our use or sharing must be made in writing.
- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We'll agree to your request as allowed by state and federal law. We take verbal requests but may ask you to confirm your request in writing. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete you can ask to change it. You must ask in writing. You must give the reasons for the change. We'll respond to your request in the time we must do so under the law. Mail this to the address below. If we deny your request,

you may add your disagreement to your HI.

- **To get an accounting** of when we shared your HI in the six years prior to your request. This won't include when we shared HI for the following reasons. (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This won't list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website.
- **In certain states, you may have the right to ask that we delete** your HI. Depending on where you live, you may be able to ask us to delete your HI. We'll respond to your request in the time we must do so under the law. If we can't, we'll tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

Using Your Rights

- **To Contact your Health Plan.** If you have questions about this notice, or you want to use your rights, call the phone number on your ID card. Or you may contact the UnitedHealth Group Call Center at 1-866-842-4968, or TTY/RTT 711.
- **To Submit a Written Request.** Mail to:

  UnitedHealthcare Privacy Office
  MN017-E300
  PO Box 1459
  Minneapolis MN 55440

- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

[1]This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to https://www.uhc.com/privacy/entities-fn-v2.

FINANCIAL INFORMATION PRIVACY NOTICE

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

Effective January 1, 2024

We[2] protect your "personal financial information" ("FI"). FI is non-health information. FI identifies you and is generally not public.

Information We Collect

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

Sharing of FI

We'll only share FI as permitted by law.

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

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

Confidentiality and Security

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

Questions About This Notice

Please **call the toll-free member phone number on health plan ID card** or contact the UnitedHealth Group Customer Call Center at 1-866-842-4968, or TTY/RTT 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.; Optum Health Care Solutions, Inc.; 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 Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and 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 a current list of health plans subject to this notice go to https://www.uhc.com/privacy/entities-fn-v2.

D. Our responsibility to give you information

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

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Enrollee Services. This is a free service to you. Our plan can also give you written materials in languages other than English, including Spanish and Amharic. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of your *Enrollee Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Enrollee Handbook*) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something isn't covered and what you can do about it (refer to **Chapter 9** of your *Enrollee Handbook*), including asking us to:
  - put in writing why something isn't covered
  - change a decision we made
  - pay for a bill you got

E. Inability of network providers to bill you directly

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

F. Your right to leave our plan

No one can make you stay in our plan if you don't want to.

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

G. Your right to make decisions about your health care

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

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

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

- **Know your choices.** You have the right to be told about all treatment options that are recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help enrollees manage their medications and use drugs safely.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we'll not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.

- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Enrollee Handbook* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

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

- Fill out a written form **giving someone the right to make health care decisions for you if you ever become unable to make decisions for yourself.**
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you **don't** want.

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

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

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

You have the right to:

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

- Change or cancel your advance directive at any time.

By law, no one can deny you care or discriminate against you based on whether you signed an advanced directive. Call Enrollee Services for more information.

G3. What to do if your instructions aren't followed

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

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

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

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

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

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

- Enrollee Services.
- The DC State Health Insurance Assistance Program (SHIP) program at 202-727-8370. For more details about the DC SHIP, refer to **Chapter 2**.
- The Office of Health Care Ombudsman and Bill of Rights at 202-724-7491. For more details about this program, refer to **Chapter 2** of your *Enrollee Handbook*.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/publications/11534medicare-rights-and-protections.pdf.)
- Medicaid Dual Choice support at 202-442-9533, Monday to Friday, 9 a.m.-4:45 p.m. TTY users should call 711.

I. Your responsibilities as a plan enrollee

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

- **Read the *Enrollee Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:

  - Covered services, refer to **Chapters 3 and 4** of your *Enrollee Handbook*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of your *Enrollee Handbook*.

- **Tell us about any other health or drug coverage you have.** We must make sure you use all of your coverage options when you get health care. Call Enrollee Services if you have other coverage.
- **Tell your doctor and other health care providers** that you're an enrollee of our plan. Show your UCard when you get services or drugs.
- **Treat those providing your care with respect and dignity.**
- **Follow the rules** of the District Dual Choice Program and UHC Dual Choice DC-Y2 (PPO D-SNP).
- **Go to scheduled appointments.**
- **Tell your doctor at least 24 hours before the appointment if you must cancel.**
- **Ask for more explanation** if you don't understand your doctor's instructions.
- **Go to the Emergency Room only if you have a medical emergency.**
- **Tell your PCP/PDP about medical and personal problems that may affect your health.**
- **Try to understand your health problems and participate in developing treatment goals.**
- **Help your doctor** in getting medical records from providers who have treated you in the past.
- **Tell UHC Dual Choice DC-Y2 (PPO D-SNP) if you were injured as the result of an accident or at work**
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most UHC Dual Choice DC-Y2 (PPO D-SNP) members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.

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

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

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

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

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

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

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

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

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

A1. About the legal terms

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

For example, we say:

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

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

B. Where to get help

B1. For more information and help

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

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

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

Help and information from Medicare

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

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

- Visit the Medicare website (medicare.gov).

Help and information from DC Medicaid Dual Choice Support

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

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

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

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

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

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

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

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

D. Problems with your benefits

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

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

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple we generally refer to medical items, services, and Part B drugs as **medical care**.

E1. Coverage decisions

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

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

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or DC Medicaid. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

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

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

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

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Enrollee Services** at the numbers at the bottom of the page.
- DC State Health Insurance Assistance Program (SHIP) at 202-727-8370.
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you're not required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
- **The Office of Health Care Ombudsman and Bill of Rights** at 202-724-7491.
- **The Office of the DC Long-Term Care Ombudsman** at 202-434-2190.

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

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

E4. Which section of this chapter can help you

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

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

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

F. Medical care

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

This section is about your benefits for medical care that's described in **Chapter 4** of your *Enrollee Handbook* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

F1. Using this section

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

1. **You think we cover medical care you need but aren't getting.**
   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.
2. **We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.**
   What you can do: You can appeal our decision. Refer to **Section F3**.
3. **You got medical care that you think we cover, but we'll not pay.**
   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.
4. **You got and paid for medical care you thought we cover, and you want us to pay you back.**
   What you can do: You can ask us to pay you back. Refer to **Section F5**.
5. **We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.**

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

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

F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **"integrated organization determination."**

You, your doctor, or your representative can ask us for a coverage decision by:

- calling: **1-866-242-7726**, TTY: **711**.
- faxing: **1-888-950-1169**
- writing:

  UnitedHealthcare Enrollee Services Department (Coverage Determination)
  P.O. Box 30769
  Salt Lake City, UT 84130-0769

  Appeals and Grievance Department (Medical appeals)
  P.O. Box 6103, MS CA120-0360
  Cypress, CA 90630-0023

  Part D Appeal and Grievance Department (Prescription appeals)
  P.O. Box 6103, MS CA120-0368
  Cypress, CA 90630-0023

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer within:

- **7 calendar days** after we get your request **for a Medicare-covered medical service or item that's subject to our prior authorization rules. For a Medicaid-covered service or item prior authorization**, we'll give you a decision as fast as your health condition requires and within 3 business days of receiving your electronic request or within 5 business days if we receive the request via mail, telephone, or fax. **For long-term services and supports authorizations**, we'll give you a decision as fast as your health condition requires and no later than thirty calendar days; provided, that you're otherwise eligible for such benefits under Medicaid.
- **14 calendar days** after we get your request **for all other medical services or items**.
- **72 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we'll tell you in writing. **We can't take extra days if your request is for a Medicare Part B drug.**

If you think we shouldn't take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.

Fast coverage decision

> The legal term for "fast coverage decision" is **"expedited determination."**

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we'll give you an answer within:

- **72 hours** after we get your request **for a Medicare-covered medical service or item**. For prior authorization of a Medicaid-covered service or item, we'll give you a decision as fast as your health condition requires and within 24 hours of receiving your request for service.
- **24 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we'll tell you in writing. **We can't take extra time if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We'll call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You're asking for coverage for medical items and/or services that you **didn't get**. You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,

- if someone makes the request on your behalf but isn't legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at **1-866-242-7726**, TTY **711**.

Ask for a standard appeal or a fast appeal in writing or by calling us at **1-866-242-7726**.

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf/ on our website at **MyUHC.com/CommunityPlan**.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
  - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
  - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.

- If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the District yourself as soon as the time is up. In the District, Fair Hearings are filed with District's Office of Administrative Hearings. You must request your Fair Hearing within 90 calendar days from the date of UHC Dual Choice DC-Y2 (PPO D-SNP)'s Level 1 decision.
- If you want to continue receiving the benefit during your Fair Hearing or appeal, you must request the Fair Hearing within 10 calendar days from the postmark on UHC Dual Choice DC-Y2 (PPO D-SNP)'s Appeal Resolution Notice or by the intended effective date of UHC Dual Choice DC-Y2 (PPO D-SNP)'s proposed action (in other words, when the benefit is to stop) — whichever is later.
- To file a request for Fair Hearing, call 202-442-9094 or write to District of Columbia Office of Administrative Hearings, Clerk of the Court, 441 4th Street, NW, Room N450 Washington, DC 20001.

- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If you think we shouldn't take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.
  - If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the District yourself as soon as the time is up. In the District, Fair Hearings are filed with District's Office of Administrative Hearings. You must request your Fair Hearing within 90 calendar days from the date of UHC Dual Choice DC-Y2 (PPO D-SNP)'s Level 1 decision.
  - If you want to continue receiving the benefit during your Fair Hearing or appeal, you must request the Fair Hearing within 10 calendar days from the postmark on UHC Dual Choice DC-Y2 (PPO D-SNP)'s Appeal Resolution Notice or by the intended effective date of UHC

Dual Choice DC-Y2 (PPO D-SNP)'s proposed action (in other words, when the benefit is to stop) — whichever is later.

- To file a request for Fair Hearing, call 202-442-9094 or write to District of Columbia Office of Administrative Hearings, Clerk of the Court, 441 4th Street, NW, Room N450 Washington, DC 20001.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights**:

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a DC Medicaid service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, DC Medicaid, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that DC Medicaid usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and DC Medicaid** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the District.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by DC Medicaid, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity"**, sometimes called the **"IRE"**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO take extra time to make a decision if your request is for a Medicare Part B drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service,** we must:
  - Authorize the medical care coverage **within 72 hours**, or
  - Provide the service **within 14 calendar days** after we get the IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**

- **within 72 hours** after we get the IRO's decision for **standard requests, or**
- **within 24 hours** from the date we get the IRO's decision for **expedited requests**.

- **If the IRO says No to part or all of your appeal,** it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that's covered by both Medicare and DC Medicaid

A Level 2 Appeal for services that DC Medicaid usually covers is a Fair Hearing with the District. In the District a Fair Hearing is filed with District's Office of Administrative Hearings. You must ask for a Fair Hearing in writing or by phone **within 90 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill.

We can't reimburse you directly for a Medicaid service or item that isn't covered by this program (for example, some community-based behavioral health services). If you get a bill for Medicaid covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.

If you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a Medicaid service or item you paid for, you'll ask us to make this a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to **Chapter 7** of your *Enrollee Handbook*.

If you ask to be paid back, you're asking for a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we'll send you the payment for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we'll send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item isn't covered or you didn't follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and DC Medicaid usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

G. Medicare Part D drugs

Your benefits as an enrollee of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that DC Medicaid may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time. For drugs covered only by Medicaid follow the process in **Section E**.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Enrollee Handbook* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that isn't on our plan's **Drug List** or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's **Drug List** but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our **Drug List** or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our **Drug List**, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4.**	Refer to **Section G4.**	Refer to **Section G4.**	Refer to **Section G5.**

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our **Drug List** or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that isn't on our Drug List**
    - You can't get an exception to the required copay amount for the drug.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

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

Our **Drug List** often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally don't approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling **1-866-242-7726**, TTY **711**, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Enrollee Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

> A "fast coverage decision" is called an **"expedited coverage determination."**

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination".**

- Start your **standard** or **fast appeal** by calling **1-866-242-7726**, TTY **711**, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

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

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.

- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.

- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity"**, sometimes called the **"IRE"**.

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file.**
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.

- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Enrollee Handbook*.

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "Important Message from Medicare." Everyone with Medicare gets a copy of this notice whenever they're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Enrollee Services at the numbers at the bottom of the page. You can also call 1 800-MEDICARE (1-800-633-4227). TTY users should call 1 877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Enrollee Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1 800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They're not part of our plan.

In the District, the QIO is Commence Health BFCC-QIO. Call them at 1-888-396-4646. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave,** you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal,** and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the QIO about your appeal, appeal to our plan directly instead. Refer to **Section G4** for information about making an appeal to us.

Ask for help if you need it. If you have questions or need help at any time:

- Call Enrollee Services at the numbers at the bottom of the page.
- Call the DC State Health Insurance Assistance Program (SHIP) at 202-727-8370.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the "**Detailed Notice of Discharge**." You can get a sample by calling Enrollee Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at **www.cms.gov/medicare/forms notices/beneficiary-notices-initiative/ffs-ma-im**.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.

- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-396-4646.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**

- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Enrollee Services at the numbers at the bottom of the page.
  - Call the DC State Health Insurance Assistance Program (SHIP) at 202-727-8370.
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of your *Enrollee Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

- If you miss the deadline for contacting the QIO, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4**.

The legal term for the written notice is "**Notice of Medicare Non-Coverage**". To get a sample copy, call Enrollee Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at cms.gov/Medicare/Medicare-General-Information/BNI.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage".**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at **1-888-396-4646**.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.

- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional DC Medicaid appeals

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

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be right for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, or if the Council denies the review request, the appeals process may not be over.

- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you decide not to accept this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You're unhappy with the quality of care, such as the care you got in the hospital.

Complaint	Example
Respecting your privacy	• You think that someone didn't respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you're being pushed out of our plan.
Accessibility and language assistance	• You can't physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Enrollee Services, or other plan staff keep you waiting too long. ◦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• You think the clinic, hospital or doctor's office isn't clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call Enrollee Services at **1-866-242-7726** for internal complaints, and/or the Medicare at **1-800-MEDICARE (1-800-633-4227)** for external complaints.

The legal term for a "complaint" is a **"grievance."**

The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Enrollee Services at **1-866-242-7726**, TTY **711**. You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- You can file a complaint by calling Enrollee Services or by writing to us. All complaints will be responded to in writing.
- When you file a complaint, by phone or in writing, we will send you an acknowledgment letter, within two (2) business days of the receipt of your complaint, to let you know we have received your complaint. We will respond to your oral or written complaint with a written resolution letter no later than the grievance time frames below.
- When you file a complaint, orally or in writing, we'll send you an acknowledgment letter, within 2 business days of the receipt of your complaint, to let you know that we have received your complaint and that we'll respond to your compliant no later than the grievance time frames below.
- When you file a complaint, we'll address it as quickly as possible but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you'll receive a letter letting you know.
- If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We'll respond to you within 24 hours of receiving your complaint. If we don't accept your complaint in the whole or in part, our written decision will explain why it was not accepted and will tell you about options you may have. The address and fax numbers for filing complaints are located in **Chapter 2** under "How to contact us when you're making a complaint about your medical care" OR "How to contact us when you're making a complaint about your Part D prescription drugs".
- **Whether you call or write, you should contact Enrollee Services right away.** You can make the complaint at any time after you had the problem you want to complain about.

The legal term for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. Whether you call or write us about your complaint, we'll send you a letter about our decision. If your health condition requires us to answer quickly, we'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a

status update and estimated time for you to get the answer.

- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don’t agree with some or all of your complaint, we’ll tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: medicare.gov/my/medicare-complaint. You don’t need to file a complaint with UHC Dual Choice DC-Y2 (PPO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn’t addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

Medicaid

You can tell Medicaid about your complaint by calling Dual Choice Support at 202-442-9533. TTY users can dial 711. You can also email DualChoice@dc.gov.

You can also file a complaint with the Office of Health Care Ombudsman and Bill of Rights by calling 202-724-7491. TTY users dial 711.

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven’t been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit hhs.gov/ocr for more information.

You may also contact the local OCR office at:

HHS Headquarters
200 Independence Avenue, S.W.
Washington, D.C. 2020

You may also have rights under the Americans with Disability Act (ADA). You can contact the local OCR office.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of your *Enrollee Handbook*.

In the District, the QIO is called Commence Health BFCC-QIO. The phone number for Commence Health BFCC-QIO is 1-888-396-4646.

Chapter 10: Ending your enrollment in our plan

Introduction

This chapter explains how you can end your enrollment with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and DC Medicaid programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Enrollee Handbook*.

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A. When you can end your enrollment in our plan

Most people with Medicare can end their enrollment during certain times of the year. Since you have DC Medicaid, you have some choices to end your enrollment with our plan any month of the year.

In addition, you may end your enrollment in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your enrollment in our plan ends on December 31 and your enrollment in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your enrollment in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for DC Medicaid or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your enrollment ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medicaid services in **Section C2**.

You can get more information about how you can end your enrollment by calling:

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP), DC SHIP at 202-727-8370. TTY users should call 711.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of your *Enrollee Handbook* for information about drug management programs.

B. How to end your enrollment in our plan

If you decide to end your enrollment you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are three ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in **Section C1**.
- Call the DC State Health Insurance Assistance Program (SHIP) at 202-727-8370, TTY 711. Section C below includes steps that you can take to enroll in a different plan, which will also end your enrollment in our plan.

C. How to get Medicare and DC Medicaid services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

C1. Your Medicare services

You have two options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your enrollment in our plan.

1. You can change to:	Here is what to do:
Original Medicare with a separate Medicare drug plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the DC State Health Insurance Assistance Program (SHIP), 202-727-8370, TTY 711, Monday-Friday, 9:30 a.m.–4:30 p.m. For more information, please visit dacl.dc.gov/service/health-insurance-counseling. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. Your entitlement to Medicaid isn't affected by your choice of Medicare coverage. You'll still be eligible for Medicaid, subject to any needed reevaluation, and your Medicaid services can continue in Medicaid Fee-for-Service.

2. You can change to:	**Here is what to do:**
Original Medicare without a separate Medicare drug plan **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the DC SHIP at 202-727-8370, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local SHIP office in your area, please visit dacl.dc.gov/service/health-insurance-counseling.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the DC State Health Insurance Assistance Program (SHIP), 202-727-8370, TTY 711, Monday-Friday, 9:30 a.m.–4:30 p.m. For more information, please visit dacl.dc.gov/service/health-insurance-counseling. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. Your entitlement to Medicaid isn't affected by your choice of Medicare coverage. You'll still be eligible for Medicaid, subject to any needed reevaluation, and your Medicaid services can continue in Medicaid Fee-for-Service.

3. You can change to:	Here is what to do:
Any Medicare health plan during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in Section A.	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the DC State Health Insurance Assistance Program (SHIP), 202-727-8370, TTY 711, Monday-Friday, 9:30 a.m.–4:30 p.m., dacl.dc.gov/service/health-insurance-counseling. **OR** Enroll in a new Medicare plan. You're automatically disenrolled from our Medicare plan when your new plan's coverage begins. Your entitlement to Medicaid isn't affected by your choice of Medicare coverage. You'll still be eligible for Medicaid, subject to any needed reevaluation, and your Medicaid services can continue in Medicaid Fee-for-Service.

C2. Your DC Medicaid services

When you change your enrollment in the Dual Choice program, both your Medicare and Medicaid coverage options change. If you choose to change your Medicare coverage to any of the options in **Chapter 10, Section C1** above, you'll be enrolled in Medicaid on a fee-for-service basis.

If you need help or more information about how to get your DC Medicaid services after you leave our plan, contact:

- The DC State Health Insurance Assistance Program (SHIP), 202-727-8370, TTY 711, Monday–Friday, 9:30 a.m.–4:30 p.m. For more information, please visit dacl.dc.gov/service/health-insurance-counseling.

Dual Choice Support at 202-442-9533, TTY 711, 9 a.m.–4:45 p.m., Monday–Friday, **dhcf.dc.gov/page/district-dual-choice-d-snps**.

D. Your medical items, services and drugs until your enrollment in our plan ends

If you leave our plan, it may take time before your enrollment ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your enrollment in UHC Dual Choice DC-Y2 (PPO D-SNP) ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

E. Other situations when your enrollment in our plan ends

These are cases when we must end your enrollment in our plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you're away from our service area for more than six months.
  - If you move or take a long trip, call Enrollee Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or aren't lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.

- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your UCard to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your enrollment for this reason.)
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will dis-enroll you from our plan.

F. Rules against asking you to leave our plan for any health-related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

G. Your right to make a complaint if we end your enrollment in our plan

If we end your enrollment in our plan, we must tell you our reasons in writing for ending your enrollment. We must also explain how you can file a grievance or make a complaint about our decision to end your enrollment. You can also refer to **Chapter 9** of your *Enrollee Handbook* for information about how to make a complaint.

H. How to get more information about ending your plan enrollment

If you have questions or would like more information on ending your enrollment, you can call Enrollee Services at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your enrollment in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Enrollee Handbook*.

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A. Notice about laws

Many laws apply to this *Enrollee Handbook*. These laws may affect your rights and responsibilities even if the laws aren't included or explained in the *Enrollee Handbook*. The main laws that apply are federal laws about the Medicare and DC Medicaid programs. Other federal and District laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, moral beliefs, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. We must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1 800-368-1019. TTY users can call 1-800-537-7697. You can also visit hhs.gov/ocr for more information.
- Call your local Office for Civil Rights.

  U.S. Dept. of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer and DC Medicaid as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and District laws and regulations relating to the legal liability of third parties for health care services to members, including Section 1902(a)(25) of the Social Security Act, 42 C.F.R. Part 433, Subpart D, and the Health Care Assistance Reimbursement Act of 1984 (DC Law 5-86: DC, Code Section 3-501 et seq.). We take all reasonable measures to ensure that DC Medicaid is the payer of last resort.

D. Third party liability and subrogation

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

1. **Our payments are less than the recovery amount.** If our payments are less than the total recovery amount from any third party (the "recovery amount"), then our reimbursement is computed as follows:
   - **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).
   - **Second:** Apply the ratio calculated above to our payment. The result is our share of procurement costs.
   - **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:
   - Our payments made on your behalf for services; or
   - 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.

E. Enrollee liability

In the event we fail to reimburse network providers' charges for covered services that are covered by both Medicare and Medicaid, you'll not be liable for any sums owed by us.

You'll be liable if you receive services from non-network providers without authorization. Neither the plan nor Medicare nor DC Medicaid will pay for those non-covered services:

- Emergency services

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

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

F. Medicare-covered services must meet requirement of reasonable and necessary

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

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

G. Non-duplication of benefits with automobile, accident or liability coverage

If you're receiving benefits as a result of other automobile, accident or liability coverage, we'll 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're entitled under other automobile, accident, or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under District and/or federal law. We will provide benefits over and above your other automobile, accident, or liability coverage, if the cost of your health care services exceeds such coverage. You're 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.

H. Acts beyond our control

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

I. Contracting medical providers and network hospitals are independent contractors

The relationships between us and our network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of UnitedHealthcare Insurance Company or one of its affiliates. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare Insurance Company or one of its affiliates is an employee or agent of the network providers or network hospitals.

J. Technology assessment

We regularly review new procedures, devices, and drugs to determine whether or not they're safe and efficacious for Enrollees. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including medical necessity and any applicable Enrollee Copayments, Coinsurance, deductibles, or other payment contributions. In determining whether to cover a service, we use proprietary technology guidelines to review new devices, procedures, and drugs, including those related to behavioral/mental health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual Enrollee, one of our Medical Directors makes a medical necessity determination based on individual Enrollee medical documentation, review of published scientific evidence, and, when appropriate, relevant specialty or professional opinion from an individual who has expertise in the technology.

K. Enrollee statements

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

L. Information upon request

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

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

M. 2026 Enrollee fraud & abuse communication

2026 Enrollee Fraud & Abuse Communication

Fraud is a serious matter. What's fraud? Fraud is making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. An example of fraud for enrollees is falsely claiming that you live in the District when you live outside the boundaries of the District of Columbia.

How you can fight health care fraud

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

Here are some examples of potential fraud cases:

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

If you suspect fraud or any other misuse of services, please let us know. It isn't required that you identify yourself or give your name. If you would like more information about what fraud is, visit UnitedHealthcare Community Plan's website at https://uhc.com/fraud. To report fraud, call UnitedHealthcare Community Plan Compliance Hotline, 1-844-359-7736, or call the DC Department of Health Care Finance's Fraud Hotline at 1-877-632-2873.

This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization won't 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.

N. How our network providers are generally compensated

Commitment of Coverage Decisions

UnitedHealthcare's Clinical Services Staff and Physicians make decisions on the health care services you receive based on the appropriateness of care and service and existence of coverage. Clinical Staff and Physicians making these decisions:

1. Don't specifically receive reward for issuing non-coverage (denial) decisions;
2. Don't offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services; and
3. Don't 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.

O. Fitness program Terms and Conditions

Eligibility Requirements

Only enrollees enrolled in a participating Medicare Plan offered by UnitedHealthcare Insurance Company ("UnitedHealthcare") and affiliates are eligible for the fitness program ("Program"), which includes, without limitation, access to standard fitness memberships at participating gyms/fitness locations, online fitness, cognitive providers and in-person and virtual classes and activities at no additional cost. By enrolling in the Program, you hereby accept and agree to be bound by these Terms and Conditions.

Enrollment Requirements

Membership and participation in the Program is voluntary. You must enroll in the Program according to the information provided on the member site or Enrollee Services. Once enrolled, you must obtain your confirmation code and provide it when requested to sign up for any Program services. Provide your confirmation code when requested when visiting a participating gym/fitness location to receive standard membership access at no additional cost, registering with an online fitness and/or cognitive providers and to gain access to classes and activities.

Please note, that by using your confirmation code, you're electing to disclose that you're an enrollee with a participating UnitedHealthcare Medicare plan. Program enrollment is on an individual basis and the Program's waived monthly membership rate for standard membership services at

participating gyms and fitness locations is only applicable to individual memberships.

You're responsible for any and all non-covered services and/or similar fee-based products and services offered by Program service providers (including, without limitation, gym/fitness centers, digital fitness offerings, digital cognitive providers, and other third party service offerings made available through the Program), including, without limitation, fees associated with personal training sessions, specialized classes, and enhanced facility membership levels beyond the standard membership level. No reimbursements will be made for any fitness program offerings. Fitness membership offerings, including visits, hours, equipment, classes, personalized fitness plans, caregiver access and activities, can vary by location. Access to gym and fitness location network varies by plan/area and may not be available on all plans.

Liability Waiver

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

Other Requirements

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

Data Requirements

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

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Optum Financial®

Privacy notice

Rev. 08/2025

Facts	What does Optum Bank do with your personal information?
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Medicare Beneficiary Identifier or Member Identification Number and account balances • Payment history and transaction history • Purchase history and account transactions When you are no longer our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share members' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their members' personal information, the reasons Optum Bank chooses to share and whether you can limit this sharing.

Reasons we can share your personal information	Does Optum Bank share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – information about your transactions and experiences, which is not used by affiliates to market their products to you	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?	**Please call 1-866-234-8913 or visit us online at optumbank.com.**

What we do	
How does **Optum Bank** protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We also have additional safeguards to protect your information and we limit who can access it.
How does **Optum Bank** collect my personal information?	We collect your personal information, for example, when you: • Use your payment card or pay a bill • Update your contact information We also collect your personal information from others, such as affiliates or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only: • Sharing for affiliates' everyday business purposes – information about your creditworthiness • Affiliates from using your information to market to you • Sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. • Our affiliates include companies within UnitedHealth Group and those companies that share the Optum name; financial companies such as Optum Financial, Inc. and UnitedHealthcare Insurance Company; and nonfinancial companies such as UHG Print Services.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • Optum Bank does not share with nonaffiliates so they can market to you.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • Optum Bank does not engage in any joint marketing.

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Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout your *Enrollee Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Enrollee Services.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your *Enrollee Handbook* explains appeals, including how to make an appeal.

Balance Billing: When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As an enrollee of UHC Dual Choice DC-Y2 (PPO D-SNP), you only have to pay our plan's allowed cost-sharing amounts when you get services covered by our plan. We don't allow network providers to "balance bill" or otherwise charge you more than the amount of cost-sharing our plan says you must pay. In some cases, out-of-network providers can balance bill you for covered services. If you obtain covered services from an out-of-network provider who does not accept Medicare assignment, you'll be responsible for the plan cost-sharing, plus any difference between the amount we pay the provider and the Medicare limiting charge.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Benefit period: The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Biological Product: A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (Go to also "Original Biological Product" and "Biosimilar").

Biosimilar: A biological product that's 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. (Go to "Interchangeable Biosimilar").

Brand name drug: A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

Care navigator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized Care Plan."

Care team: Refer to "Interdisciplinary Care Team."

Catastrophic Coverage Stage: The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,100 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 in charge of Medicare. **Chapter 2** of your *Enrollee Handbook* explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".

Coinsurance: An amount you may be required to pay, expressed as a percentage (for example, 20%), as your share of the cost for services or prescription drugs. As a enrollee, you don't have coinsurance, but you must continue to pay your Medicare premiums if you have Medicare.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Copay: A fixed amount you pay as your share of the cost each time you get certain services or drugs. For example, you might pay $2 or $5 for a service or a drug.

Cost-sharing: Amounts you have to pay when you get certain drugs. Cost-sharing includes copays.

Cost-sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the *Drug List*) is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your *Enrollee Handbook* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

DC Medicaid: This is the name of the District of Columbia's (the District's) Medicaid program. DC Medicaid is run by the District and is paid for by the District and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary by jurisdiction, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Deductible: The amount you must pay for health care or prescriptions before our plan pays. As an enrollee, you have no deductibles.

Disenrollment: The process of ending your enrollment in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee: A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Dual eligible individual: A person who qualifies for Medicare and DC Medicaid coverage.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you're a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Enrollee (enrollee of our plan, or plan enrollee): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the District.

***Enrollee Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights,

and what you must do as a member of our plan.

Enrollee Services: A department in our plan responsible for answering your questions about enrollment, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Enrollee Handbook* for more information about Enrollee Services.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded Services: Services that aren't covered by this health plan.

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

Fair Hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a Fair Hearing. If the Fair Hearing is decided in your favor, we must give you the service you asked for.

Generic drug: A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Home health care: Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart in Chapter 4, Section D under the heading "Home health agency care." If you need home health care services, our Plan will cover these services for you provided the Medicare and/or DC Medicaid coverage requirements are met. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you're also getting a covered skilled service. Home health services don't usually include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

Hospice care: A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that's given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain.

The focus is on care, not cure. For more information on hospice care visit **medicare.gov** and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or call **1-800-633-4227**. TTY users should call **1-877-486-2048**.

Hospital inpatient stay: A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Services if you get any bills you don't understand. Because we pay the entire cost for your services, you don't owe any cost-sharing. Providers shouldn't bill you anything for these services.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.

Individualized Care Plan (ICP or Care Plan): A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Initial coverage stage: This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Inpatient: A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic

substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs **(Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The **Drug List** tells you if there are any rules you need to follow to get your drugs. The **Drug List** is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF). LTSS is available to enrollees who meet certain clinical and financial requirements. For more information on LTSS, call Enrollee Services at **1-866-242-7726**.

Low-income subsidy (LIS): Refer to "Extra Help".

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.

Medicaid (or Medical Assistance): A program run by the federal government and the District that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medically accepted indication: A use of a drug that's either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and Micromedex DRUGDEX Information system.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage: A Medicare program, also known as "Medicare Part C" or "MA", that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits. A Medicare Advantage Plan can be i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part

A and Medicare Part B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual”.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as “Medicare Advantage” or “MA”, that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to **Chapter 5** of your *Enrollee Handbook* for more information.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They’re licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and don’t charge members an extra amount.
- While you’re an enrollee of our plan, you must use network providers to get covered services. Network providers are also called “plan providers”.

Nursing home or facility: A place that provides care for people who can’t get their care at home but don’t need to be in the hospital.

Ombudsperson: An office in your District that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of your *Enrollee Handbook*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of your *Enrollee Handbook* explains coverage decisions.

Original Biological Product: A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It's also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out of network pharmacies unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. **Chapter 3** of your *Enrollee Handbook* explains out-of-network providers or facilities.

Out-of-Pocket Threshold: The maximum amount you pay out of pocket for Part D drugs.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Part D Late Enrollment Penalty: An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that's 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're first eligible to join a Part D plan. If you lose Extra Help, you may be subject

to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Preferred Provider Organization (PPO) Plan: A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan enrollees for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Enrollee cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from in-network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network(non-preferred) providers.

Preventive services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Premium: The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription drug benefit manager: Third party prescription drug organization responsible for processing and paying prescription drug claims, developing, and maintaining the formulary, and negotiating discounts and rebates with drug manufacturers.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your *Enrollee Handbook* for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of your *Enrollee Handbook*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs* and the rules are posted on our website.

Program of All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE isn't available in all states. If you would like to know if PACE is available in your state, please contact Enrollee Services at **1-866-242-7726**.

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

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't 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 doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Enrollee Handbook* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of your *Enrollee Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Enrollee Handbook* to learn more about rehabilitation services.

Retail walk-In clinic: A provider location that generally does not require appointments and may be a standalone location or located in a retail store, supermarket, or pharmacy. Walk-In Clinic Services are subject to the same cost sharing as Urgent Care Centers. (See the Medical Benefit Chart in Chapter 4.)

Service area: A geographic area where a health plan accepts members if it limits enrollment based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Special Needs Plan: A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to obtain services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).

UHC Dual Choice DC-Y2 (PPO D-SNP) Enrollee Services:

CALL	**1-866-242-7726** Calls to this number are free. 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September Enrollee Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 8:00 a.m.–8:00 p.m., 7 days a week, October–March; 8:00 a.m.–5:30 p.m., Monday–Friday, April–September
WRITE	UHC Community Plan P.O. Box 30769 Salt Lake City, UT 84130-0769
WEBSITE	**MyUHC.com/CommunityPlan**

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 C** of the *Enrollee Handbook*.

PRA Disclosure Statement

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