

Every drug on our plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the 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.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

1. Check the most recent Drug List we provided electronically.
2. Visit the plan's website (myUHC.com/CommunityPlan). The Drug List on the website is always the most current.
3. Call Customer Service at 1-844-368-7150 (TTY users call 711) to find out if a particular drug is on the plan's Drug List or ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (myUHC.com/CommunityPlan) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Customer Service at 1-844-368-7150 (TTY users call 711).

Section 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

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

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care

provider, and different restrictions or cost-sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Customer Service at 1-844-368-7150 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you (go to Chapter 9).

What is a compounded drug?

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

Does my Part D plan cover compounded drugs?

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

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

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

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

Compound Type	Medicare Coverage
Compound containing an ingredient not approved or supported for use in a compound	Compound is not covered by Part D. You are responsible for the entire cost

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

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

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan based on specific criteria before we agree to cover the drug for you. This is called **“prior authorization”**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don’t get this approval, your drug might not be covered by the plan. Our plan’s prior authorization criteria can be obtained by calling Customer Service at 1-844-368-7150 (TTY users call 711) or on our website myUHC.com/CommunityPlan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, the plan may require you to try Drug A first. If Drug A doesn’t work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **“step therapy”**. Our plan’s step therapy criteria can be obtained by calling Customer Service at 1-844-368-7150 (TTY users call 711) or on our website myUHC.com/CommunityPlan.

Quantity limits

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

Section 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn’t on our drug list (formulary) or has restrictions. For example:

- ☐ The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn’t covered.
- ☐ The drug is covered, but there are extra rules or restrictions on coverage
- ☐ The drug is covered, but in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be
- ☐ **If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.**

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

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

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

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

- ☐ **If you're a new member**, we'll cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- ☐ **If you were in the plan last year**, we'll cover a temporary supply of your drug during the first 90 days of the calendar year.
- ☐ This temporary supply will be for at least a 30-day supply. If your prescription is written for fewer days, we'll allow multiple fills to provide up to at least a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- ☐ **For members who've been in the plan for more than 90 days and live in a long-term care facility and need a supply right away:**
We'll cover at least a 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- ☐ **For current members with level of care changes:**
There may be unplanned transitions such as hospital discharges (including psychiatric hospitals) or level of care changes (i.e., changing long-term care facilities, exiting and entering a long-term care facility, ending Part A coverage within a skilled nursing facility, or ending hospice coverage and reverting to Medicare coverage) that can occur anytime. If you're prescribed a drug that's not 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.

For questions about a temporary supply, call Customer Service at 1-844-368-7150 (TTY users call 711).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by the plan may work just as well for you. Call Customer Service at 1-844-368-7150 (TTY users call 711) to ask for a list of covered

drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

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

If you're a current member and a drug you take will be removed from the formulary or restricted in some way for next year, we'll tell you about any change before the new year. You can ask for an exception before next year and we'll give you an answer 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.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Customer Service at 1-844-368-7150 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

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

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 Specialty Tier aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

Section 6 Our Drug List can change during the year

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

- ☐ **Add or remove drugs from the Drug List**

- ☐ **Move a drug to a higher or lower cost-sharing tier**
- ☐ **Add or remove a restriction on coverage for a drug**
- ☐ **Replace a brand name drug with a generic version of the drug**
- ☐ **Replace an original biological product with an interchangeable biosimilar version of the biological product**

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug you take.

Changes to drug coverage that affect you during this plan year

- ☐ **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
 - ☐ When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
 - ☐ We'll make these immediate changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
 - ☐ We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- ☐ **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List.**
 - ☐ When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
 - ☐ We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
 - ☐ We'll tell you at least 30 days before we make the change or tell you about the change and cover at least a 30-day fill of the version of the drug you're taking.
- ☐ **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
 - ☐ Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change.

☐ **Making other changes to drugs on the Drug List**

- ☐ We may make other changes once the year has started that affect drugs you are taking. For example, we might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
- ☐ We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you're taking.

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

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

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

In general, changes that won't affect you during the current plan year are:

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

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan 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 to drugs you take that will impact you during the next plan year.

Section 7 Types of drugs we don't cover

Some kinds of prescription drugs are excluded. This means Medicare doesn't pay for these drugs.

If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- ☐ Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B
- ☐ Our plan can't cover a drug purchased outside the United States or its territories
- ☐ Our plan can't cover **off-label** use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex

DRUGDEX Information System. **Off-label** use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs listed below aren't covered by Medicare. However, some of these drugs may be covered for you under your Oklahoma Health Care Authority (Medicaid) drug coverage. Please check your Oklahoma Health Care Authority (Medicaid) Drug list to see if any of the drugs listed below are covered:

- ☐ Non-prescription drugs (also called over-the-counter drugs)
- ☐ Drugs used to promote fertility
- ☐ Drugs used for the relief of cough or cold symptoms
- ☐ Drugs used for cosmetic purposes or to promote hair growth
- ☐ Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- ☐ Drugs used for the treatment of sexual or erectile dysfunction
- ☐ Drugs used for treatment of anorexia, weight loss, or weight gain
- ☐ Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you **get Extra Help from Medicare** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. (Go to the plan's Drug List or call Customer Service at 1-844-368-7150 (TTY users call 711) for more information.) If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

Section 8 How to fill a prescription

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

If you don't have your plan membership information with you, you or the pharmacy can call the plan to get the information, or you can ask the pharmacy to look up our 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.** You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask the plan for reimbursement.

Section 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

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

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

Section 9.2 As a resident in a long-term care (LTC) facility

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

Check your **Pharmacy Directory** (myUHC.com/CommunityPlan) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Customer Service at 1-844-368-7150 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also get drug coverage from an employer or retiree group plan

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

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

Special note about 'creditable coverage':

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

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

Keep any notices about creditable coverage, because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

Section 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care. We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems like:

- ☐ Possible medication errors
- ☐ Drugs that may not be necessary because you take another similar drug to treat the same condition
- ☐ Drugs that may not be safe or appropriate because of your age or gender
- ☐ Certain combinations of drugs that could harm you if taken at the same time
- ☐ Prescriptions for drugs that have ingredients you're allergic to
- ☐ Possible errors in the amount (dosage) of a drug you take
- ☐ Unsafe amounts of opioid pain medications

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

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

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

- ☐ Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- ☐ Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- ☐ Limiting the amount of opioid or benzodiazepine medications we'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 prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter

confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) programs to help members manage their medications

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

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

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about these programs, contact Customer Service at 1-844-368-7150 (TTY users call 711).

Chapter 6:

What you pay for Part D drugs

Section 1 What you pay for Part D drugs

We use “drug” in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Medicaid.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan’s “Real-Time Benefit Tool” to look up drug coverage (myUHC.com/CommunityPlan), the cost you see shows an estimate of the out-of-pocket costs you’re expected to pay. You can also get information provided by the “Real-Time Benefit Tool” by calling Customer Service at 1-844-368-7150 (TTY users call 711).

How can you get information about your drug costs?

Because you're eligible for Oklahoma Health Care Authority (Medicaid), you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you have Extra Help, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Customer Service at 1-844-368-7150 (TTY users call 711) and ask for the “LIS Rider.”

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

There are 3 different types of out-of-pocket costs covered for Part D drugs that you may be asked to pay:

- ☐ **“Deductible”** is the amount you pay for drugs before our plan starts to pay our share.
- ☐ **“Copayment”** is a fixed amount you pay each time you fill a prescription.
- ☐ **“Coinsurance”** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

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

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

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

- ☐ The amount you pay for drugs when you're in any of the following drug payment stages:
 - ☐ The Deductible Stage
 - ☐ The Initial Coverage Stage
- ☐ Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- ☐ 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, and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$2,100 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- ☐ Your monthly premium
- ☐ Drugs you buy outside the United States and its territories
- ☐ Drugs that aren't covered by our plan
- ☐ Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- ☐ Drugs covered by Oklahoma Health Care Authority (Medicaid) only
- ☐ Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- ☐ Payments you make toward drugs not normally covered in a Medicare Prescription Drug Plan
- ☐ Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- ☐ Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- ☐ Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Customer Service at 1-844-368-7150 (TTY users call 711).

Tracking your out-of-pocket total costs

- ☐ The Part D Explanation of Benefits (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches \$2,100, the Part D EOB will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- ☐ **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

Section 2 Drug payment stages for UHC Dual Complete OK-S002 (HMO-POS D-SNP) members

There are 3 **drug payment stages** for your Medicare Part D drug coverage under UHC Dual Complete OK-S002 (HMO-POS D-SNP). How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- ☐ **Stage 1: Yearly Deductible Stage**
- ☐ **Stage 2: Initial Coverage Stage**
- ☐ **Stage 3: Catastrophic Coverage Stage**

Section 3 Your Part D Explanation of Benefits (EOB) explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- ☐ **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- ☐ **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month we'll send you a Part D EOB. The Part D EOB includes:

- ☐ **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- ☐ **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 displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- ☐ **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost-sharing for each prescription claim, if applicable.

Section 3.1 Help us keep our information about your drug payments up to date

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

- ☐ **Show your UCard every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- ☐ **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
 - ☐ When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
 - ☐ When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
 - ☐ Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
 - ☐ If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- ☐ **Send us information about the payments others 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 charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- ☐ **Check the written report we send you.** When you get the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Customer Service at 1-844-368-7150 (TTY users call 711). You can also view your EOB on our website at myUHC.com/CommunityPlan. Be sure to keep these reports.

Section 4 The Deductible Stage

Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage doesn't apply to most members. If you get Extra Help, this payment stage doesn't apply to you.

Look at the separate insert (the "LIS Rider") for information about your deductible amount.

If you don't get Extra Help, the Deductible Stage is the first payment stage for your drug coverage. You'll pay a yearly deductible of \$615 on Tier 2, Tier 3, Tier 4 and Tier 5 drugs. **You must pay the**

full cost of your Tier 2, Tier 3, Tier 4 and Tier 5 drugs until you reach our plan's deductible amount. For all other drugs, you won't have to pay any deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines. The **"full cost"** is usually lower than the normal full price of the drug, since our plan negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay \$615 for your Tier 2, Tier 3, Tier 4 and Tier 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

Section 5 The Initial Coverage Stage

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

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

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.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 our plan's Drug List.

Your pharmacy choices

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

- ☐ A network retail pharmacy
- ☐ A pharmacy that isn't in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- ☐ Our plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and the plan's **Pharmacy Directory (myUHC.com/CommunityPlan)**.

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.

Section 5.2 Your costs for a one-month supply of a covered drug

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

Coinsurance is a portion or part of the total cost, typically as a percentage. With this plan, you pay part of the cost of Tier 2, Tier 3, Tier 4 and Tier 5 drugs. For example, if your coinsurance is 25% and the total cost of your prescription is \$100, you would pay \$25. The plan pays the rest. You pay the full cost of your drugs until you meet the deductible, then you'll start paying the coinsurance amount.

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

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 Oklahoma Health Care Authority (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 will pay the following for your covered prescription drugs if you DO NOT qualify for "Extra Help" from Medicare to help pay for your prescription drug costs:

Your costs for a one-month supply of a covered Part D drug

Tier	Standard retail and mail-order^ cost-sharing (in-network) (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 Preferred Generic	Standard retail: \$0 copayment Standard mail-order: Mail order is not available for drugs in Tier 1.	\$0 copayment	\$0 copayment*
Cost-Sharing Tier 2 Generic	Standard retail: 25% coinsurance Standard mail-order: Mail order is not available for drugs in Tier 2.	25% coinsurance	25% coinsurance*
Cost-Sharing Tier 3 Preferred Brand	Standard retail: 25% coinsurance Standard mail-order: Mail order is not available for drugs in Tier 3.	25% coinsurance	25% coinsurance*
Cost-Sharing Tier 3 Covered Insulin Drugs ¹	Standard retail: 25% coinsurance, up to \$35 copayment Standard mail-order: Mail order is not available for drugs in Tier 3.	25% coinsurance, up to \$35 copayment	25% coinsurance, up to \$35 copayment*
Cost-Sharing Tier 4 Non-Preferred Drug	Standard retail: 25% coinsurance Standard mail-order: 25% coinsurance	25% coinsurance	25% coinsurance*

Your costs for a one-month supply of a covered Part D drug

Cost-Sharing Tier 5 Specialty Tier	Standard retail: 25% coinsurance Standard mail-order: 25% coinsurance	25% coinsurance	25% coinsurance*
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^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.

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

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.

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.

Go to Section 8 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.

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

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

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- ☐ If you're responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- ☐ If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. 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.

Section 5.4 Your costs for a long-term (100-day) supply of a covered Part D drug

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

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 Oklahoma Health Care Authority (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 will pay the following for your covered prescription drugs if you DO NOT 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.

Your costs for a long-term (100-day) supply of a covered Part D drug

Tier	Standard retail cost-sharing (in-network) (100-day supply)	Mail-order cost-sharing (100-day supply)
Cost-Sharing Tier 1 Preferred Generic	\$0 copayment	\$0 copayment
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 ¹	25% coinsurance, up to \$105 copayment	25% coinsurance, up to \$105 copayment
Cost-Sharing Tier 4 Non-Preferred Drug ²	A long-term supply is not available for drugs in Tier 4.	A long-term supply is not available for drugs in Tier 4.

Your costs for a long-term (100-day) supply of a covered Part D drug

Cost-Sharing Tier 5 Specialty Tier ²	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
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¹ You pay no more than 25% of the total drug cost or a \$105 copayment, whichever is lower, for each 3-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.

² Limited to a 30-day supply

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **\$2,100**. You then move to the Catastrophic Coverage Stage.

The Part D EOB you get will help you keep track of how much you, our plan, and any third parties, have spent on your behalf for your drugs during the year. Not all members will reach the \$2,100 limit in a year.

We'll let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

Section 6 The Catastrophic Coverage Stage

- ☐ In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the \$2,100 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year. During this payment stage, you pay nothing for your covered Part D drugs.

Section 7 Additional benefits information

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

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

Section 8 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 Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan’s Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven’t paid your deductible. Refer to our plan’s Drug List or call Customer Service at 1-844-368-7150, TTY 711, for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

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

Your costs for a Part D vaccine depend on 3 things:

1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).

- ☐ Most adult Part D vaccines are recommended by ACIP and cost you nothing.

2. Where you get the vaccine.

- ☐ The vaccine itself may be dispensed by a pharmacy or provided by the doctor’s office.

3. Who gives you the vaccine.

- ☐ A pharmacist or another provider may give the vaccine in the pharmacy. Or a provider may give it in the doctor’s office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you’re in.

- ☐ When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you’ll be reimbursed the entire cost you paid.
- ☐ Other times when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don’t allow pharmacies to give certain vaccines.)

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

Situation 2: You get the Part D vaccine at your doctor’s office.

- ☐ When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- ☐ You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- ☐ For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance or copayment for the vaccine (including administration).

Situation 3: You buy the Part D vaccine itself at the network pharmacy and take it to your doctor's office where they give you the vaccine.

- ☐ For most adult Part D vaccines, you pay nothing for the vaccine itself.
- ☐ For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself.
- ☐ When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- ☐ You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- ☐ For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance or copayment for the vaccine administration.

Chapter 7:

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

Section 1 Situations when you should ask us to pay our share for covered services or drugs

Our network providers bill our plan directly for your covered services and drugs – you shouldn't get a bill for covered services or drugs. If you get a bill for the full cost of medical care or drugs you got, send this bill to us so that we can pay it. When you send us the bill, we'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly.

If you have already paid for a Medicare service or item covered by our plan, you can ask our plan to pay you back (paying you back is often called reimburse you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter. When you send us a bill you've already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

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

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

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

Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill our plan.

- ☐ If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
- ☐ You may get a bill from the provider asking for payment that you think you don't owe. Send us this bill, along with documentation of any payments you already made.

- ☐ If the provider is owed anything, we'll pay the provider directly.
- ☐ If you already paid more than your share of the cost for the service, we'll determine how much you owed and pay you back for our share of the cost.
- ☐ You can also receive emergency or urgently needed services from a provider outside the United States. If you receive emergency or urgently-needed services outside of the United States, the provider may require that you pay for the cost of the services in full. Ask for a written, detailed bill or receipt showing the specific services provided to you. Send a copy of the itemized bill or an itemized receipt to us to pay you back. You should be prepared to assist us in obtaining all of the information necessary to properly process your request for reimbursement, including medical records. Foreign emergency and urgently needed care is covered only if paid directly by you and submitted to us for reimbursement, or when reimbursement is requested directly by you and when we can make arrangements to pay the rendering provider directly. Invoices and supporting medical records must be submitted directly by you or directly by the rendering provider. Any services or documentation submitted to us by third-party billers, intermediaries or claims management companies are not reimbursable.

2. When a network provider sends you a bill you think you shouldn't pay

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

- ☐ If you are eligible for Medicare cost-sharing assistance under Medicaid, we do not allow providers to bill you for 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.
- ☐ 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 resolve the billing problem.
- ☐ If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made. Ask us to pay you back 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 a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

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

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

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

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

5. When you pay the full cost for a prescription because you don't have our UCard with you

If you don't have our UCard with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

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

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

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

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

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

Important: If you are 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 will pay the full cost of emergency services received outside of the United States at the time you receive services. To receive reimbursement from us, you must do the following:

- ☐ Pay your bill at the time it is received. We will reimburse you for the difference between the amount of your bill and your cost share for the services as outlined in Chapter 4 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 are being asked to pay your bill for worldwide emergency services and are unable to make the payment, please call Customer Service for additional assistance and we may be able to 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 are not 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 will not 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 are 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 are not covered worldwide emergency or urgently needed services as described in this Evidence of Coverage, you are fully responsible for payment for those services. Neither the plan nor Medicare will pay for services received outside of the United States that are not 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'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

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

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

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

- ☐ You don't have to use the form, but it'll help us process the information faster.

- ☐ Download a copy of the form from our website (myUHC.com/CommunityPlan) or call Customer Service and ask for the form.

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

Part D Prescription drug payment requests:

Optum Rx

P.O. Box 650287

Dallas, TX 75265-0287

Medical claims payment requests:

UnitedHealthcare

P.O. Box 5270

Kingston, NY 12402-5270

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

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

Section 3 We'll consider your request for payment and say yes or no

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

- ☐ If we decide that the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost for the service or drug. If you have already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- ☐ If we decide that the medical care or drug is **not** covered, or you did **not** follow all the rules, we won't pay for our share of the cost of the care or drug. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

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

Chapter 8:

Your rights and responsibilities

Section 1 Our plan must honor your rights and cultural sensitivities

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

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

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. We're required to give you information about our 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, call Customer Service number at 1-844-368-7150 for additional information (TTY users should call 711).

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comuniqué con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Se nos exige que le proporcionemos la información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener más información de nuestra parte de una forma que le resulte conveniente, llame al número de Servicio al Cliente al 1-844-368-7150 (los usuarios de TTY deben llamar al 711).

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

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

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

Sección 1.1 Usted tiene derecho a recibir información sobre la organización, sus servicios, sus profesionales médicos y proveedores, además de los derechos y las responsabilidades de los miembros. Debemos proporcionar la información de una forma que le resulte conveniente y de acuerdo con sus sensibilidades culturales (en otros idiomas además del inglés, en braille, en letra grande o en otros formatos alternativos, etc.)

Nuestro plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se presten de una manera culturalmente competente y estén a disposición de todos los miembros, incluidos aquellos que tienen un dominio limitado del inglés, habilidades limitadas de lectura, discapacidad auditiva o aquellos que tienen distintos orígenes culturales y étnicos. Los ejemplos de cómo un plan puede cumplir estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traducción, servicios de interpretación, teletipos o conexión al servicio de TTY (teléfono de texto o teletipo).

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Se nos exige que le proporcionemos la información sobre los beneficios de nuestro plan en un formato que sea accesible y apropiado para usted. Para obtener más información de nuestra parte de una forma que le resulte conveniente, llame al número de Servicio al Cliente al 1-844-368-7150 (los usuarios de TTY deben llamar al 711).

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. We're required to give you information about our 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, call Customer Service number at 1-844-368-7150 for additional information (TTY users should call 711).

Nuestro plan debe proporcionar a las mujeres que son miembros la opción de acceso directo a un especialista en salud de la mujer dentro de la red para recibir servicios para el cuidado de la salud preventivos y de rutina de la mujer.

Si los proveedores dentro de la red de nuestro plan para una especialidad no están a su disposición, nuestro plan tiene la responsabilidad de encontrar proveedores de especialidades fuera de la red para que le proporcionen el cuidado que necesita. En este caso, usted solo pagará el costo compartido que corresponde dentro de la red. Si se encuentra en una situación en la que no hay especialistas dentro de la red de nuestro plan que presten un servicio que necesita, llame a nuestro plan para obtener información sobre dónde visitar para recibir este servicio a un costo compartido igual que si se tratara de uno dentro de la red.

Si tiene alguna dificultad para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, consultar a un especialista en salud de la mujer o encontrar un especialista de la red, llame a Servicio al Cliente para presentar una queja formal (los números de teléfono aparecen en la portada de esta guía). También puede presentar una queja ante Medicare si llama al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

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

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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

How to Receive Care After Hours

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

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

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

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

- ☐ Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- ☐ You have rights related to your information and controlling how your health information is used. We give you a written notice, called a Notice of Privacy Practice, that talks about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- ☐ We make sure that unauthorized people don't see or change your records.
- ☐ Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, we're required to get written permission from you or someone you've given legal power to make decisions for you first.
- ☐ There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
 - ☐ We're required to release health information to government agencies that are checking on quality of care.
 - ☐ Because you're a member of our plan through Medicare, we're required to give Medicare your health information including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Customer Service at 1-844-368-7150 (TTY users call 711).

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

- ☐ How we may use your HI.
- ☐ When we can share your HI with others.
- ☐ What rights you have 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 will notify you by mail or e-mail. We will also post the new notice on our website. Any changes to the notice will apply to all HI we have. We will 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 will 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 are 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 will not 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 are unable to tell us if we can share your HI or not. If you are unable to tell us what you want, we will 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 will 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 will only use or share your HI as described in this notice or with your written consent. We will get your written consent to share psychotherapy notes about you, except in certain cases allowed by law. We will get your written consent to sell your HI to other people. We will get your written consent to use your HI in certain marketing mailings. If you give us your consent, you may take it back. To find out how, call the phone number on your UCard.

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 will try to honor your request, but we do not 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 will 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 will 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 will not 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 will not list the disclosures that federal law does not require us to track.
- ☐ **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website.
- ☐ **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 will respond to your request in the time we must do so under the law. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

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 UCard.** Or you may contact the UnitedHealth Group Call Center at 1-844-368-7150, 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 will not take any action against you for filing a complaint.

¹ This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to 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

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

Information We Collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and Security

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

Questions About This Notice

Please **call the toll-free member phone number on UCard** or contact the UnitedHealth Group Customer Call Center at 1-844-368-7150, 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 uhc.com/privacy/entities-fn-v2.

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

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

If you want any of the following kinds of information, call Customer Service at 1-844-368-7150 (TTY users call 711):

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

Section 1.5 You have the right to know your treatment options and participate in decisions about your health care

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

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

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

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

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

- ☐ Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- ☐ **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- ☐ **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service for assistance in locating an advanced directive form.
- ☐ **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- ☐ **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed?

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

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

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

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

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

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

If you believe you've been treated unfairly or your rights haven't been respected, and it's not about discrimination, you can get help dealing with the problem you're having from these places:

- ☐ **Call Customer Service at 1-844-368-7150 (TTY users call 711).**
- ☐ **Call your local SHIP at 1-800-763-2828.**
- ☐ **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

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

Get more information about your rights from these places:

- ☐ **Call Customer Service at 1-844-368-7150 (TTY users call 711).**

- ☐ For information on the quality program for your specific health plan, call Customer Service. You can also access this information online at uhc.com/medicare/resources.html. Open the Additional Medicare information and forms section and select Find information. Then select Other resources and plan information and then Commitment to quality.
- ☐ **Call your local SHIP at 1-800-763-2828.**
- ☐ **Contact Medicare.**
 - ☐ Visit medicare.gov to read the publication Medicare Rights & Protections (available at: (Medicare Rights & Protections)
 - ☐ Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

Section 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Service at 1-844-368-7150 (TTY users call 711).

- ☐ **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this **Evidence of Coverage** to learn what's covered and the rules you need to follow to get covered services.
 - ☐ Chapters 3 and 4 give details about medical services.
 - ☐ Chapters 5 and 6 give details about Part D drug coverage.
- ☐ **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- ☐ **Tell your doctor and other health care providers that you're enrolled in our plan.** Show your UCard and Medicaid card whenever you get medical care or Part D drugs.
- ☐ **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - ☐ To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
 - ☐ Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
 - ☐ If you have questions, be sure to ask and get an answer you can understand.
- ☐ **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- ☐ **Pay what you owe.** As a plan member, you're responsible for these payments:
 - ☐ In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For most Plan members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan.
 - ☐ For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.

- ☐ If you're required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.
- ☐ If you're required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to stay a member of our plan.
- ☐ **If you move outside our plan service area, you can't stay a member of our plan.**
- ☐ **If you move within our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- ☐ If you move, tell Social Security (or the Railroad Retirement Board).

Chapter 9:

If you have a problem or complaint (coverage decisions, appeals, complaints)

Section 1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on 2 things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you would like help deciding whether to use the Medicare process or the Medicaid process, or both, please contact Customer Service.
2. The type of problem you are having:
 - ☐ For some problems, you need to use the **process for coverage decisions and appeals**.
 - ☐ For other problems, you need to use the **process for making complaints** (also called grievances).

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

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

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

- ☐ Uses simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination” or “at-risk determination” and “independent review organization” instead of “Independent Review Entity.”
- ☐ It also uses abbreviations as little as possible.

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

Section 2 Where to get more information and personalized help

We’re always available to help you. Even if you have a complaint about our treatment of you, we’re obligated to honor your right to complain. You should always call customer service at

1-844-368-7150 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

You can also contact Medicare for help.

- ☐ Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- ☐ Visit www.Medicare.gov.

You can get help and information from Medicaid

For more information and help in handling a problem, you can also contact Oklahoma Health Care Authority (Medicaid). Here are two ways to get information directly from Oklahoma Health Care Authority (Medicaid):

- ☐ You can call 1-800-987-7767. TTY users should call 711.
- ☐ You can visit the Oklahoma Health Care Authority (Medicaid) website (<https://www.oklahoma.gov/ohca.html>).

Section 3 Which process to use for your problem

Because you have Medicare and get help from Medicaid, you have different processes you can use to handle your problem or complaint. Which process you use depends on if the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, use the Medicare process. If your problem is about a benefit covered by Medicaid, use the Medicaid process. If you'd like help deciding whether to use the Medicare process or the Medicaid process, call Customer Service at 1-844-368-7150 (TTY users call 711).

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

Is your problem about Medicare benefits or Medicaid benefits?

If you would like help deciding whether your problem is about Medicare benefits or Medicaid benefits, please contact Customer Service.

My problem is about **Medicare** benefits.

Go to **Section 4, Handling problems about your Medicare benefits.**

My problem is about **Medicaid** coverage.

Go to **Section 12, Handling problems about your Medicaid benefits.**

Problems about your Medicare benefits

Section 4 Handling problems about your Medicare benefits

Section 4.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

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

To figure out which part of this chapter will help with your problem or concern, about your **Medicare** benefits, use this chart

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to **Section 5, A guide to coverage decisions and appeals**.

No.

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

Section 5 A guide to coverage decisions and appeals

Section 5.1 Get help asking for a coverage decision or making an appeal

Coverage decisions and appeals deal with problems about 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 Medicare Part B drugs as medical care. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think that you need. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can appeal the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

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

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

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

- ☐ You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- ☐ Go to Section 6.4 of this chapter for more information about Level 2 appeals for medical care.
- ☐ Part D appeals are discussed further in Section 7.

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

Section 5.2 Rules and deadlines for different situations

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

- ☐ **Call Customer Service at 1-844-368-7150 (TTY users call 711).**
- ☐ Get free help from your State Health Insurance Assistance Program.
- ☐ **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer Service at 1-844-368-7150 (TTY users call 711) and ask for the Appointment of Representative form. (The form is also available at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
 - ☐ For medical care, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it'll be automatically forwarded to Level 2.
 - ☐ For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- ☐ **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
 - ☐ If you want a friend, relative, or another person to be your representative, call Customer Service at 1-844-368-7150 (TTY users call 711) and ask for the Appointment of Representative form. (The form is also available at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
 - ☐ We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- ☐ **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.3 Which section of this chapter gives the details for your situation?

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations in this chapter:

- ☐ **Section 6:** Medical care: How to ask for a coverage decision or make an appeal

- ☐ **Section 7:** Part D drugs: How to ask for a coverage decision or make an appeal
- ☐ **Section 8:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- ☐ **Section 9:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (**Applies only to these services:** home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Customer Service at 1-844-368-7150 (TTY users call 711). You can also get help or information from your SHIP.

Section 6 Medical care: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the **medical benefits chart**. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 6.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 6.2.**
3. You got medical care that you believe should be covered by our plan, but we have said we won't pay for this care. **Make an appeal. Section 6.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

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

Section 6.2 How to ask for a coverage decision

Legal Terms

A coverage decision that involves your medical care is called an **organization determination**.

A fast coverage decision is called an **expedited determination**.



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

A standard coverage decision is usually made within 7 calendar days or when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- ☐ You may **only ask** for coverage for medical items and/or services (not requests for payment for items and/or services already got).
- ☐ You can get a fast coverage decision **only** if using the standard deadlines **could cause serious harm to your health or hurt your ability to function**.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- ☐ Explains that we'll use the standard deadlines.
- ☐ Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- ☐ Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.



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

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



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

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request **for a medical item or service** that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a **Part B drug**, we'll give you an answer **within 72 hours** after we get your request.

- ☐ **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- ☐ If you believe we shouldn't take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 11 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- ☐ **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- ☐ If you believe we shouldn't take extra days, you can file a fast complaint. (Go to Section 11 for information on complaints.) We'll call you as soon as we make the decision.
- ☐ **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no.



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

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

Legal Terms

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

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



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

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

- ☐ If you’re appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we’ll give you a fast appeal.
- ☐ The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2.



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

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



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

- ☐ When we review your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.

- ☐ We'll gather more information if needed and may contact you or your doctor.

Deadlines for a "fast appeal"

- ☐ For fast appeals, 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 us to.
 - ☐ If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
 - ☐ If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- ☐ **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- ☐ **If our answer is no to part or all of what you asked for**, we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- ☐ For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your **health** condition requires us to.
 - ☐ However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
 - ☐ If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 11 for information on complaints.)
 - ☐ If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- ☐ **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- ☐ If our plan says no to part or all of your appeal, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 6.4 The Level 2 appeal process

Legal Term

The formal name for the independent review organization is the **Independent Review Entity**. It's sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. 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.



Step 1: The independent review organization reviews your appeal.

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

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2

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

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2

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



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

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

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



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

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

Section 6.5 If you're asking us to pay you back for our share of a bill you got for medical care

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

To make this appeal, follow the process for appeals that we describe in Section 6.3. For appeals concerning reimbursement, note:

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

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

Section 7.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

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

- ☐ If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.

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

Part D coverage decisions and appeals

Legal Term	An initial coverage decision about your Part D drugs is called a “coverage determination.”
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A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- ☐ Asking to cover a Part D drug that is not on the plan’s **Drug List. Ask for an exception. Section 7.2**
- ☐ Asking to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 7.2**
- ☐ Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier **Ask for an exception. Section 7.2**
- ☐ Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4**
- ☐ Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4**

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

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

Section 7.2 Asking for an exception

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

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

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a Part D drug for you that is not on our Drug List. If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in **Tier 4**.

You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.

2. Removing a restriction for a covered drug. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our **Drug List**. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our plan's Drug List is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

- ☐ If our **Drug List** contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
- ☐ If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
- ☐ If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- ☐ If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- ☐ You cannot ask us to change the cost-sharing tier for any drug in Tier 5 Specialty Tier.
- ☐ If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called alternative drugs. If an alternative drug would be just as effective as the drug you're asking for and wouldn't cause more side effects or other health problems, we generally **won't** approve your request for an exception. If you ask us for a tiering exception, we generally won't approve your request for an exception unless all the alternative drugs in the lower

cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

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

Section 7.4 How to ask for a coverage decision, including an exception

Legal Term

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



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

“**Standard coverage decisions**” are made **within 72 hours** after we receive your doctor's statement. “**Fast coverage decisions**” are made within **24 hours** after we receive your doctor's statement.

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

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



Step 2: Ask for a standard coverage decision or a fast coverage decision.

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

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

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



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

Deadlines for a fast coverage decision

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

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

- ☐ We must generally give you our answer **within 72 hours** after we receive your request.
 - ☐ For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
 - ☐ If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- ☐ **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- ☐ **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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



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

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

Section 7.5 How to make a Level 1 appeal

Legal Terms

An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

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



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

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

- ☐ If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- ☐ The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4 of this chapter.



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

- ☐ **For standard appeals, submit a written request.** Chapter 2 has contact information.
- ☐ **For fast appeals either submit your appeal in writing or call us at 1-844-368-7150.** Chapter 2 has contact information.
- ☐ **We must accept any written request**, including a request submitted on the CMS Model Redetermination Request Form, which is available on our website (myUHC.com/CommunityPlan). Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- ☐ **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- ☐ **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.



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

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

Deadlines for a fast appeal

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

Deadlines for a standard appeal for a drug you didn't get yet

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

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

- ☐ We must give you our answer **within 14 calendar days** after we get your request.
 - ☐ If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- ☐ **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 30 calendar days after we get your request.
- ☐ **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.



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

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

Section 7.6 How to make a Level 2 appeal

Legal Term

The formal name for the Independent Review Organization is the Independent Review Entity. It is sometimes called the IRE.

The **independent review organization** is an independent organization hired by Medicare. It 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.



Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- ☐ If our plan says no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization.
- ☐ You must make your appeal request within 65 calendar days from the date on the written notice.
- ☐ If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an at-risk determination under our drug management program, we'll automatically forward your request to the IRE.
- ☐ We'll send the information about your appeal to the independent review organization. This information is called your case file. **You have the right to ask us for a copy of your case file.**



Step 2: The independent review organization reviews your appeal.

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

Deadlines for “fast” appeal

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

Deadlines for standard appeal

- ☐ For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.



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

For “fast” appeals

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

For “standard” appeals

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

What if the independent review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called upholding the decision. It’s also called turning down your appeal.) In this case, the independent review organization will send you a letter that:

- ☐ Explaining its decision.
- ☐ Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- ☐ Telling you the dollar value that must be in dispute to continue with the appeals process.



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

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

Section 8 **How to ask us to cover a longer inpatient hospital stay if you think you’re being discharged too soon**

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

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

- ☐ The day you leave the hospital is called your **“discharge date.”**

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

Section 8.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells about your rights

Within two calendar days of being admitted to the hospital, you will be given a written notice called **An Important Message from Medicare about Your Rights**. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service at 1-844-368-7150 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- ☐ Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- ☐ Your right to be involved in any decisions about your hospital stay.
- ☐ Where to report any concerns you have about the quality of your hospital care.
- ☐ Your right to **ask for an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. You will be asked to sign the written notice to show that you received it and understand your rights.

- ☐ You or someone who is acting on your behalf will be asked to sign the notice.
- ☐ Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.

3. Keep your copy of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- ☐ If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- ☐ To look at a copy of this notice in advance, call Customer Service at 1-844-368-7150 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048). You can also see the notice online at cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Section 8.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- ☐ **Follow the process.**
- ☐ **Meet the deadlines.**
- ☐ **Ask for help if you need it.** If you have questions or need help, call Customer Service at 1-844-368-7150 (TTY users call 711). Or, call your State Health Insurance Assistance Program (SHIP) for personalized help. Oklahoma Medicare Assistance Program (MAP) 1-800-763-2828, TTY users call 711. SHIP contact information is also available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.



Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- ☐ The written notice you got (**An Important Message from Medicare About Your Rights**) tells you how to reach this organization. Or, find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- ☐ To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge**.
- ☐ If you meet this deadline, you may stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.
- ☐ If you do **not** meet this deadline, contact us. If you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

- ☐ You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service at 1-844-368-7150 (TTY users call 711) or

1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048. Or you can get a sample notice online at cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.



Step 2: The Quality Improvement Organization conducts an independent review of your case.

- ☐ Health professionals at the Quality Improvement Organization (we will call them the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- ☐ The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- ☐ By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.



Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- ☐ If the independent review organization says **yes, we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- ☐ You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- ☐ If the review organization says **no**, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.
- ☐ If the review organization says **no** to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.



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

- ☐ If the Quality Improvement Organization has said **no** to your appeal, **and** you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you're going to Level 2 of the appeals process.

Section 8.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.



Step 1: Contact the Quality Improvement Organization again and ask for another review.

- ☐ You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said **no** to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.



Step 2: The Quality Improvement Organization does a second review of your situation.

- ☐ Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.



Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision.

If the independent review organization says yes:

- ☐ **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- ☐ You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- ☐ It means they agree with the decision they made on your Level 1 appeal.
- ☐ The notice you get will tell you in writing what you can do if you wish to continue with the review process.



Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

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

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

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying our share of the cost for your care.**

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

Section 9.1 We'll tell you in advance when your coverage will be ending

Legal Term

"Notice of Medicare Non-Coverage." It tells you how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. You receive a notice in writing at least two calendar days before our plan is going to stop covering your care. The notice tells you:

- ☐ The date when we will stop covering the care for you.
- ☐ How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.

2. You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it. Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

Section 9.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- ☐ **Follow the process.**
- ☐ **Meet the deadlines.**
- ☐ **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.



Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- ☐ The written notice you received (Notice of Medicare Non-Coverage) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- ☐ You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- ☐ If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.



Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term

“Detailed Explanation of Non-Coverage.” Notice that provides details on reasons for ending coverage.

What happens during this review?

- ☐ Health professionals at the Quality Improvement Organization (“the reviewers”) will ask you, or your representative, why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- ☐ The review organization will also look at your medical information, talk with your doctor, and review the information that our plan has given to them.
- ☐ By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.



Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- ☐ If the reviewers say **yes** to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- ☐ You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

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



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

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

Section 9.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.



Step 1: Contact the Quality Improvement Organization again and ask for another review.

- ☐ You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said **no** to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.



Step 2: The Quality Improvement Organization does a second review of your situation.

- ☐ Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.



Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- ☐ **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- ☐ You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

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



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

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

- ☐ The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 10 Taking your appeal to Level 3, 4, and 5

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

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

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

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

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

- ☐ **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - ☐ If we decide **not** to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
 - ☐ If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- ☐ **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
 - ☐ If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - ☐ If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

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

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

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

Section 10.2 Appeal Levels 3, 4, and 5 for Part D Drug Requests

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

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

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

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

- ☐ **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- ☐ **If the answer is no, the appeals process may or may not be over.**
 - ☐ If you decide to accept this decision that turns down your appeal, the appeals process is over.

- ☐ If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

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

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

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

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

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

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

Complaint	Example
Quality of your medical care	☐ Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	☐ Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service,	☐ Has someone been rude or disrespectful to you? ☐ Are you unhappy with our Customer Service?

Complaint	Example
or other negative behaviors	☐ Do you feel you are being encouraged to leave the plan?
Waiting times	☐ Are you having trouble getting an appointment, or waiting too long to get it? ☐ Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Customer Service or other staff at our plan? ☐ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	☐ Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	☐ Did we fail to give you a required notice? ☐ Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you have asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: ☐ You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. ☐ You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. ☐ You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. ☐ You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms

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

Section 11.3 You can also make complaints about quality of care to the Quality Improvement Organization



Step 1: Contact us promptly – either by phone or in writing.

- ☐ **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.
- ☐ **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- ☐ We must receive your complaint within 60 calendar days of the event or incident you are complaining about. If something kept you from filing your complaint (you were sick, we provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days. We will address your complaint as quickly as possible but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.
If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint. The address and fax numbers for filing complaints are located in Chapter 2 under "How to contact us when you are making a complaint about your medical care" or for Part D prescription drug complaints "How to contact us when you are making a complaint about your Part D prescription drugs."
- ☐ The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.



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

- ☐ **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- ☐ **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

- ☐ **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint”.** If you have a “fast complaint,” it means we will give you **an answer within 24 hours.**
- ☐ **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

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

When your complaint is about **quality of care**, you also have 2 extra options:

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

Or

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

Section 11.5 You can also tell Medicare about your complaint

You can submit a complaint about UHC Dual Complete OK-S002 (HMO-POS D-SNP) directly to Medicare. To submit a complaint to Medicare, go to [medicare.gov/MedicareComplaintForm/home.aspx](https://www.medicare.gov/MedicareComplaintForm/home.aspx). You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Problems about your Medicaid benefits

Section 12 Handling problems about your Medicaid benefits

You can get help and information from Oklahoma Health Care Authority (Medicaid).

For more information and help in handling a problem, you can also contact Oklahoma Health Care Authority (Medicaid).

If you have Medicare and Medicaid, some of your plan services may also be covered by your State Oklahoma Health Care Authority (Medicaid) program. Therefore, if you believe that we improperly denied you a service or payment for a service, you may also have the right to ask your State Oklahoma Health Care Authority (Medicaid) program to pay for the service. You may also have appeals and grievances related to Medicaid-covered services. Please see your Medicaid Handbook for more information, or contact your State Oklahoma Health Care Authority (Medicaid) agency at the contact information listed in Chapter 2, Section 6 of this booklet.

The Plan will provide reasonable assistance determined by your needs. This may include, but not limited to, helping you complete forms, reviewing your Medicaid benefit and addressing claims questions, complaints and/or appeals.

Chapter 10:

Ending membership in our plan

Section 1 Ending your membership in our plan

Ending your membership in the plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- ☐ You might leave our plan because you decide you **want** to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- ☐ There are also limited situations where you do not choose to leave, but we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and you'll continue to pay your cost share until your membership ends.

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

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

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- ☐ Original Medicare **with** a separate Medicare drug plan,
- ☐ Original Medicare **without** a separate Medicare drug plan (If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.), or
- ☐ If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable prescription drug coverage for a continuous period of 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Call your State Medicaid Office at 1-800-987-7767 to learn about your Medicaid plan options.

- ☐ Other Medicare health plan options are available during the **Open Enrollment Period**. Section 2.2 tells you more about the Open Enrollment Period.
- ☐ Your membership will usually end on the first day of the month after we get your request to change our plan. Your enrollment in your new plan will also begin on this day.

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

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- ☐ The **Open Enrollment Period** is from **October 15 to December 7**.
- ☐ **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - ☐ Another Medicare health plan, with or without drug coverage.
 - ☐ Original Medicare **with** a separate Medicare drug plan.
 - ☐ Original Medicare **without** a separate Medicare drug plan.
 - ☐ **Your membership will end in our plan** when your new plan's coverage starts on January 1.

If you get Extra Help from Medicare to pay for your drug coverage costs: 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 opt out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make **one** change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- ☐ **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- ☐ **During the Medicare Advantage Open Enrollment Period** you can:
 - ☐ Switch to another Medicare Advantage Plan with or without drug coverage.
 - ☐ Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- ☐ **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

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

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

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit Medicare.gov.

- ☐ Usually, when you move.
- ☐ If you have Medicaid.
- ☐ If you're eligible for Extra Help paying for Medicare drug coverage.
- ☐ If we violate our contract with you.
- ☐ If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital.

Note: If you're in a drug management program, you may only be eligible for certain Special Enrollment Periods. Chapter 5, Section 10 tells you more about drug management programs.

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

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- ☐ Another Medicare health plan with or without drug coverage.
- ☐ Original Medicare with a separate Medicare drug plan.
- ☐ Original Medicare **without** a separate Medicare drug plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Your membership will usually end on the first day of the month after we get your request to change our plan.

If you get Extra Help from Medicare to pay for your drug coverage costs: 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 opt out of automatic enrollment.

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

Section 2.5 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- ☐ **Call Customer Service** at 1-844-368-7150 (TTY users call 711).
- ☐ Find the information in the **Medicare & You 2026** handbook.

- ☐ Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
☐ Another Medicare health plan.	☐ Enroll in the new Medicare health plan ☐ You'll automatically be disenrolled from our plan when your new plan's coverage starts.
☐ Original Medicare with a separate Medicare drug plan.	☐ Enroll in the new Medicare drug plan ☐ You'll automatically be disenrolled from our plan when your new drug plan's coverage starts.
☐ Original Medicare without a separate Medicare drug plan.	☐ Send us a written request to disenroll or visit our website to disenroll online. Call Customer Service at 1-844-368-7150 (TTY users call 711) if you need more information on how to do this. ☐ You can also call Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. ☐ You'll be disenrolled from our plan when your coverage in Original Medicare starts.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your Oklahoma Health Care Authority (Medicaid) benefits, contact Oklahoma Health Care Authority (Medicaid), at 1-800-987-7767, 8 a.m. - 5 p.m. CT, Monday - Friday. TTY users call 711. Ask how joining another plan or returning to Original Medicare affects how you get your Oklahoma Health Care Authority (Medicaid) coverage.

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

Until your membership ends, and your new Medicare and Medicaid coverage starts, you must continue to get your medical items, services and prescription drugs through our plan.

- ☐ **Continue to use our network providers to get medical care.**
- ☐ **Continue to use our network pharmacies or mail order to get your prescriptions filled.**

- ☐ **If you're hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you're discharged (even if you're discharged after your new health coverage starts).**

Section 5 We must end our plan membership in certain situations

We must end your membership in our plan if any of the following happen:

- ☐ If you no longer have Medicare Part A and Part B.
- ☐ If you're no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. We must notify you in writing that you have a 6 month grace period to regain eligibility before you are disenrolled. For more information on the grace period and how it may affect your costs under this plan, please see Chapter 4, Section 1.1.
- ☐ If you do not pay your medical spend down, if applicable.
- ☐ If you move out of our service area.
- ☐ If you're away from our service area for more than 6 months.
 - ☐ If you move or take a long trip, call Customer Service at 1-844-368-7150 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- ☐ If you become incarcerated (go to prison).
- ☐ If you're no longer a United States citizen or lawfully present in the United States.
- ☐ If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- ☐ If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- ☐ 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. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- ☐ If you let someone else use your UCard to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
 - ☐ If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- ☐ If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Customer Service at 1-844-368-7150 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Our plan isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

Chapter 11:

Legal notices

Section 1 Notice about governing law

The principal law that applies to this **Evidence of Coverage** document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

Section 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call us at Customer Service 1-844-368-7150 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

Section 4 Third party liability and subrogation

If you suffer an illness or injury for which any third party is alleged to be liable or responsible due to any negligent or intentional act or omission causing illness or injury to you, you must promptly notify us of the illness or injury. We will send you a statement of the amounts we paid for services provided in connection with the illness or injury. If you recover any sums from any third party, we shall be reimbursed out of any such recovery from any third party for the payments we made on your behalf, subject to the limitations in the following paragraphs.

- 1) **Our payments are less than the recovery amount.** If our payments are less than the total recovery amount from any third party (the “recovery amount”), then our reimbursement is computed as follows:
 - a) **First:** Determine the ratio of the procurement costs to the recovery amount (the term “procurement costs” means the attorney fees and expenses incurred in obtaining a settlement or judgment).
 - b) **Second:** Apply the ratio calculated above to our payment. The result is our share of procurement costs.
 - c) **Third:** Subtract our share of procurement costs from our payments. The remainder is our reimbursement amount.
- 2) **Our payments equal or exceed the recovery amount.** If our payments equal or exceed the recovery amount, our reimbursement amount is the total recovery amount minus the total procurement costs.
- 3) **We incur procurement costs because of opposition to our reimbursement.** If we must bring suit against the party that received the recovery amount because that party opposes our reimbursement, our reimbursement amount is the lower of the following:
 - a) Our payments made on your behalf for services; or
 - b) the recovery amount, minus the party’s total procurement cost.

Subject to the limitations stated above, you agree to grant us an assignment of, and a claim and a lien against, any amounts recovered through settlement, judgment or verdict. You may be required by us and you agree to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain our right to reimbursement.

Section 5 Member liability

In the event we fail to reimburse a provider’s charges for covered services, you will not be liable for any sums owed by us. Neither the plan nor Medicare will pay for non-covered services.

If you enter into a private contract with a non-network provider, neither the plan nor Medicare will pay for those services.

Section 6 Medicare-covered services must meet requirement of reasonable and necessary

In determining coverage, services must meet the reasonable and necessary requirements under Medicare in order to be covered under your plan, unless otherwise listed as a covered service. A service is “reasonable and necessary” if the service is:

- ☐ Safe and effective;
- ☐ Not experimental or investigational; and
- ☐ Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
 1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition or to improve the function of a malformed body member;
 2. Furnished in a setting appropriate to the patient’s medical needs and condition;
 3. Ordered and furnished by qualified personnel;
 4. One that meets, but does not exceed, the patient’s medical need; and
 5. At least as beneficial as an existing and available medically appropriate alternative.

Section 7 Non duplication of benefits with automobile, accident or liability coverage

If you are receiving benefits as a result of other automobile, accident or liability coverage, we will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments may reasonably be expected, and to notify us of such coverage when available. If we happen to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, we may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law. We will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage. **You are required to cooperate with us in obtaining payment from your automobile, accident or liability coverage carrier. Your failure to do so may result in termination of your plan membership.**

Section 8 Acts beyond our control

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within our control), or any other emergency or similar event not within the control of us, network providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information, then we shall attempt to arrange for covered services insofar as practical and according to our best judgment. Neither we nor any network provider shall have any liability or obligation for delay or failure to provide or arrange for covered services if such delay is the result of any of the circumstances described above.

Section 9 Contracting medical providers and network hospitals are independent contractors

The relationships between the plan and network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of the plan. An agent would be anyone authorized to act on the plan's behalf.

Section 10 Technology assessment

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

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

Section 11 Member statements

In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such representation will void coverage or reduce covered services under this Evidence of Coverage or be used in defense of a legal action unless it is contained in a written application.

Section 12 Information upon request

As a plan member, you have the right to request information on the following:

- ☐ General coverage and comparative plan information
- ☐ Utilization control procedures
- ☐ Quality improvement programs
- ☐ Statistical data on grievances and appeals
- ☐ The financial condition of UnitedHealthcare Insurance Company or one of its affiliates

Section 13 2026 Enrollee Fraud & Abuse Communication

2026 Enrollee Fraud & Abuse Communication
How you can fight healthcare fraud

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

Here are some examples of potential Medicare fraud cases:

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

To report a potential case of fraud in a Medicare benefit program, call UHC Dual Complete OK-S002 (HMO-POS D-SNP) Customer Service at 1-844-368-7150 (TTY 711), 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.

This hotline allows you to report cases anonymously and confidentially. We will make every effort to maintain your confidentiality. However, if law enforcement needs to get involved, we may not be able to guarantee your confidentiality. Please know that our organization will not take any action against you for reporting a potential fraud case in good faith.

You may also report potential medical or prescription drug fraud cases to the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SafeRx (1-877-772-3379) or to the Medicare program directly at (1-800-633-4227). The Medicare fax number is 1-717-975-4442 and the website is [medicare.gov](https://www.medicare.gov).

Section 14 Commitment of Coverage Decisions

UnitedHealthcare's Clinical Services Staff and Physicians make decisions on the health care services you receive based on the appropriateness of care and service and existence of coverage. Clinical Staff and Physicians making these decisions: 1. Do not specifically receive reward for issuing non-coverage (denial) decisions; 2. Do not offer incentives to physicians or other health care professionals to encourage inappropriate underutilization of care or services; and 3. Do not hire, promote, or terminate physicians or other individuals based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Section 15 Fitness program Terms and Conditions

Renew Active Plan Year 2026 Disclaimers

The Renew Active® Program and its gym network varies by plan/area and may not be available on all plans. Participation in the Renew Active program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew

Active includes standard fitness membership at participating locations and other offerings. The participating locations and offerings may change at any time. Fitness membership equipment, classes and activities may vary by location. Certain services, classes, activities and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company 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 is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor.

Eligibility Requirements

Only members 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 Customer Service. 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 are electing to disclose that you are a Renew Active member with a participating UnitedHealthcare Medicare plan. Program enrollment is on an individual basis and the Program's waived monthly membership rate for standard membership services at participating gyms and fitness locations is only applicable to individual memberships.

You are responsible for any and all non-covered services and/or similar fee-based products and services offered by Program service providers (including, without limitation, gym/fitness centers, digital fitness offerings, digital cognitive providers 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.

Community Resources, Classes and Activities Disclaimer

Information about classes and activities in your area is being made available so you will have an opportunity to learn about some community resources that may help your overall health and well-being. This information is provided solely as a convenience, and participation is voluntary. While the resources mentioned herein are at no additional cost, please note that charges may apply for

other programs, classes, activities or services listed on a third-party website or otherwise offered by such third party. UnitedHealthcare does not endorse third-party organizations providing classes and activities and is not responsible for the information, products or services these organizations provide or the content on any linked site or any link contained in a linked site. These resources are not meant to replace professional health care and should not be used for emergency or urgent care needs. If you have health concerns, or before starting a new workout or diet program, please talk with your doctor. You and your health care provider must ultimately determine if you want to participate in these classes and activities. Be mindful that, if a resource is being offered on the internet, internet forums may contain misinformation.

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 are not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor.

UnitedHealthcare and its respective subsidiaries and affiliates do not endorse and are not responsible for the services or information provided by third parties, the content on any linked site, or for any injuries you may sustain while participating in any 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 will be responsible for paying the standard membership rates of the such service provider should you elect to continue to receive services from a service provider once that service provider ceases to participate in our Program. If you wish to cancel your membership with such service provider, you can opt to do so per the cancellation policy of the applicable service provider, including the applicable gym or fitness location. You should review your termination rights with a service provider when you initially elect to sign up with such service provider.

Data Requirements

The Program administrator and/or your service provider will collect and electronically send and/or receive the minimum amount of your personal information required in order to facilitate the Program in accordance with the requirements of applicable laws, including privacy laws. Such

required personal information includes, but is not limited to, program confirmation code, gym/fitness location/provider membership ID, activity year and month, and monthly visit count. By enrolling in the Program, you authorize the Program administrator and your service provider to request and/or provide such personal information.

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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 .
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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.

Chapter 12

Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of UHC Dual Complete OK-S002 (HMO-POS 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.

Benefit period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that'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 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 substituted for the original biological product at the pharmacy without needing a new prescription (Go to Interchangeable Biosimilar).

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,100 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 that administers Medicare.

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

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

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles. Coinsurance for in-network services is based upon contractually negotiated rates (when available for the specific covered service to which the coinsurance applies) or Medicare Allowable Cost, depending on our contractual arrangements for the service.

Compendia – Medicare-recognized reference books for drug information and medically accepted indications for Part D coverage.

Complaint – The formal name for making a complaint is filing a grievance. The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or “copay”) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example \$10), rather than a percentage.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2) any fixed copayment amount that a plan requires when a specific service or drug is received; or 3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

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

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

Covered Services – The term we use in this EOC to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don’t need skilled medical care or skilled nursing care. Custodial care, provided by people who don’t have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you’re required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month’s supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month’s supply in our plan is 30 days, then your daily cost-sharing rate is \$1 per day.

Daily Cost Share applies only if the drug is in the form of a solid oral dose (e.g., tablet or capsule) when dispensed for less than a one-month supply under applicable law. The Daily Cost Share requirements do not apply to either of the following:

1. Solid oral doses of antibiotics.
2. Solid oral doses that are dispensed in their original container or are usually dispensed in their original packaging to assist patients with compliance.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist’s time to prepare and package the prescription.

Dually Eligible Individuals – A person who is eligible for Medicare and Medicaid coverage.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the person’s eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you’re a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a

bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

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 (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Chapter 4, Section 2.1 under the heading "Home health agency care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain.

The focus is on care, not cure. For more information on hospice care visit [medicare.gov](https://www.medicare.gov) and under “Search Tools” choose “Find a Medicare Publication” to view or download the publication “Medicare Hospice Benefits.” Or, call (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day/7 days a week.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you’ll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won’t pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you’re first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you’re eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Integrated D-SNP – A D-SNP 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 also known as full-benefit dually eligible individuals.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Institutional Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

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

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan’s full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums,

Medicare Part A and Part B premiums, applicable Medicaid cost-shares, and prescription drugs don't count toward the maximum out-of-pocket amount. If you're eligible for Medicare cost-sharing assistance under Medicaid, you aren't responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.) Go to Chapter 4, Section 1.3 for information about your maximum out-of-pocket amount.

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

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

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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

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

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

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

Medicare Allowable Cost – The maximum price of a service for reimbursement purposes under Original Medicare.

Medicare Assignment – In Original Medicare, a doctor or supplier “accepts assignment” when he or she agrees to accept the Medicare-approved amount as full payment for covered services.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term

Medicare-Covered Services doesn't include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – 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.

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our plan, or “Plan Member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 1, Section 3.2)

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

Network Provider – “Provider” is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. “Network providers” have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called “plan providers.”

Original Biological Product – A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare (also called the Annual Enrollment Period).

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called “coverage decisions” in this document.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and

prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren’t covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn’t have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren’t employed, owned, or operated by our plan.

Out-of-pocket costs – Go to the definition for “cost-sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out-of-pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Customer Service.

Part C – Go to **Medicare Advantage (MA) plan**.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you’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.

Point of Service (POS) Plan – As a member of this Point of Service (POS) plan you may receive covered services from network providers. You may also receive covered routine dental services from providers who are not contracted with UnitedHealthcare.

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 drug list (formulary), and negotiating discounts and rebates with drug manufacturers.

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).

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – For medical services it means a process where your doctor or treating provider must receive approval in advance before certain medical services will be provided or payable. For certain drugs it means a process where you or your provider must receive approval in advance before certain drugs will be provided or payable. This approval is based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria is posted on our website.

Prosthetics and Orthotics – Medical devices including, 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 practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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

Real-Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Retail Walk-In Clinic – A provider location that generally does not require appointments and may be a standalone location or located in a retail store, supermarket or pharmacy. Walk-In Clinic Services are subject to the same cost-sharing as Urgent Care Centers. (See the Benefit Chart in Chapter 4)

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan may disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on

a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

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

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

UHC Dual Complete OK-S002 (HMO-POS D-SNP) Customer Service:



Call **1-844-368-7150**

Calls to this number are free. 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept. Customer Service also has free language interpreter services available for non-English speakers.

TTY 711

Calls to this number are free. 8 a.m.-8 p.m.: 7 Days Oct-Mar; M-F Apr-Sept.



Write: **P.O. Box 30770**
Salt Lake City, UT 84130-0770



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 3 of the Evidence of Coverage.

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