Member Handbook 2026

UHC Dual Complete TX-Y1 (HMO-POS D-SNP)

myUHC.com/CommunityPlan

Toll-free **1-866-944-4983**, TTY **711**
8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept

United Healthcare
Community Plan

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UHC Dual Complete TX-Y1 (HMO-POS D-SNP) Member Handbook

January 1, 2026 – December 31, 2026

Your Health and Drug Coverage under UHC Dual Complete TX-Y1 (HMO-POS D-SNP)

Member Handbook introduction

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

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

When this **Member Handbook** says "we", "us", "our", or "our plan", it means UHC Dual Complete TX-Y1 (HMO-POS D-SNP).

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call **1-800-256-6533** (TTY **711**), 8 a.m.–8 p.m. local time, M–F.

ATENCIÓN: Si habla español, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al **1-800-256-6533** (TTY **711**), de 8 a.m. a 8 p.m., hora local, de lunes a viernes. La llamada es gratuita.

This document is available for free in Spanish.

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

You can call the Member Services and ask us to make a note in our system that you would like this document in Spanish, large print, braille, or audio now and in the future.

Disclaimers

- Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a contract with the State Medicaid Program. Enrollment in the plan depends on the plan's contract renewal with Medicare. Benefits and/or copayments may change on January 1, 2027.
- UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.
- The healthy food and utility benefit is a special supplemental benefit only available to chronically ill enrollees with a qualifying condition, such as high blood pressure, high cholesterol, chronic and disabling mental health conditions, diabetes and/or cardiovascular disorders, and who also meet all applicable plan coverage criteria. There may be other qualified conditions not listed.
- Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.

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

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

Chapter 1

Getting started as a member

Chapter 1

Getting started as a member

Introduction

This chapter includes information about UHC Dual Complete TX-Y1 (HMO-POS D-SNP), a health plan that covers or coordinates all of your Medicare and STAR+PLUS services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

Table of Contents

Section A Welcome to our plan

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

Section B Information about Medicare and STAR+PLUS

Section B1 Medicare

Medicare is the federal health insurance program for:

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

Section B2 STAR+PLUS

STAR+PLUS is the name of Texas Medicaid program. STAR+PLUS is run by the state and is paid for by the state and the federal government. STAR+PLUS helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

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

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

Medicare and the state of Texas approved our plan. You can get Medicare and STAR+PLUS services through our plan as long as:

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

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

Section C Advantages of this plan

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

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

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

Section D Our plan's service area

Our service area includes this county in Texas: Harris county.

Only people who live in our service area can join our plan.

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

Section E What makes you eligible to be a plan member

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

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for STAR+PLUS **and** at least one of the following:

  - have a physical disability or a mental disability and qualify for Supplemental Security Income (SSI), **or**
  - qualify for STAR+PLUS because you receive Home and Community-based Services (HCBS) waiver services; **and**
- you're NOT enrolled in one of the following 1915(c) waiver programs:
  - Community Living Assistance and Support Services (CLASS)
  - Deaf Blind with Multiple Disabilities Program (DBMD)
  - Home and Community-based Services (HCBS)
  - Texas Home Living Program (TxHmL)

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

Call Member Services for more information.

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

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

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

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

We'll send you more information about this HRA.

Section G Your service coordination team and service plan

Section G1 Service coordination team

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

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

Section G2 Service plan

Your service coordination team works with you to make a service plan. A service plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and Long-Term Services and Supports (LTSS) or other services.

Your service plan includes:

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

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

Section H Your monthly costs for UHC Dual Complete TX-Y1 (HMO-POS D-SNP)

Your costs may include the following:

- Plan premium (**Section H1**)
- Monthly Medicare Part B Premium (**Section H2**)
- Optional Supplemental Benefit Premium (**Section H3**)
- Medicare Prescription Payment Plan Amount (**Section H4**)

In some situations, your plan premium could be less.

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and SPAPs. The “Extra Help” program helps people with limited resources pay for their drugs. Learn more about these programs in **Chapter 2, Section H2**. If you qualify, enrolling in the program might lower your monthly plan premium.

If you **already** get help from one of these programs, **the information about premiums in this Member Handbook may not apply to you**. We sent you a separate insert, called the “Member Handbook 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 Member Services at the number at the bottom of this page and ask for the “LIS Rider”.

Section H1 Plan premium

As a member of our plan, you pay a monthly plan premium unless you qualify for “Extra Help” with your prescription drug costs. You will not pay a monthly Plan premium (prescription drug plan

premium) if you qualify for "Extra Help". People with Medicare and Medicaid automatically qualify for "Extra Help." Because you qualify for "Extra Help," for 2026 the monthly premium for our plan is $0.

Section H2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some members are required to pay other Medicare premiums. As explained in **Section E** above to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most UHC Dual Complete TX-Y1 (HMO-POS D-SNP) members, Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and Part B premium.

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

Section H3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called "optional supplemental benefits", you pay additional premium each month for these extra benefits. Refer to **Chapter 4, Section E** for details.

Section H4 Medicare Prescription Payment Amount

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from your plan for your drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

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

Section I This Member Handbook

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

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

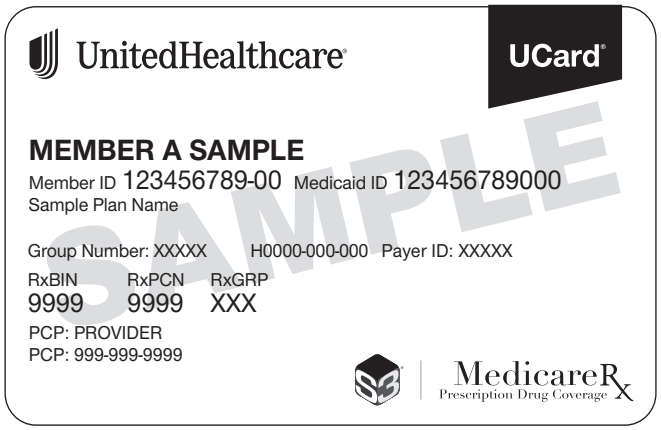
The contract is in effect for the months you're enrolled in our plan between January 1, 2026 and December 31, 2026.

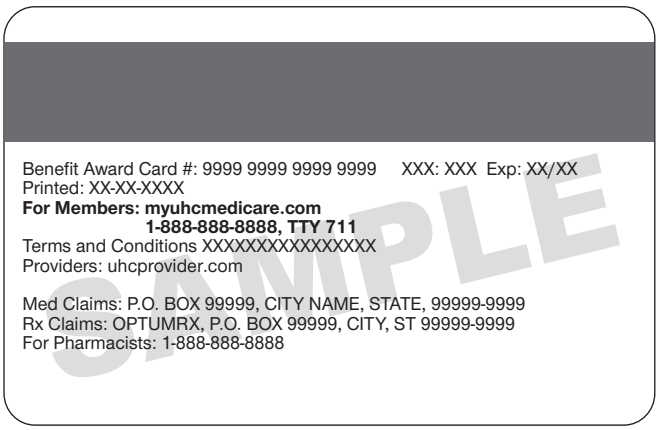
Section J Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a **Provider and Pharmacy Directory**, a List of Durable Medical Equipment (DME), and information about how to access a **List of Covered Drugs**, also known as a **Drug List** or **Formulary**.

Section J1 Your Member ID Card

Under our plan, you have one card for your Medicare and STAR+PLUS services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card, from here on referred to you as your UnitedHealthcare UCard:





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

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your STAR+PLUS card to get most services. Keep those cards in a safe place in case you need them later. If you show your Medicare card instead of your UnitedHealthcare UCard, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show

your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this **Member Handbook** to find out what to do if you get a bill from a provider.

Section J2 Provider and Pharmacy Directory

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

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

Definition of network providers

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

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

Definition of network pharmacies

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

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

List of Durable Medical Equipment (DME)

We included our List of DME with this **Member Handbook**. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at the address at the bottom of the page. Refer to **Chapters 3 and 4** of this **Member Handbook** to learn more about DME equipment.

Section J3 List of Covered Drugs

Our plan has a **List of Covered Drugs**. We call it the **Drug List** for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The **Drug List** must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your **Drug List** unless they have been removed and replaced as described in **Chapter 5**. Medicare approved the UHC Dual Complete TX-Y1 (HMO-POS D-SNP) **Drug List**.

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

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

Section J4 The Explanation of Benefits

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options. **Chapter 6** of this **Member Handbook** gives more information about the EOB and how it helps you track your drug coverage.

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

Section K How to keep your membership record up to date

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

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

Tell us right away about the following:

- changes to your name, address, or phone number;

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

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

Section K1 Privacy of personal health information (PHI)

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

Chapter 2

Important phone numbers and resources

Chapter 2

Important phone numbers and resources

Introduction

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

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Section A Member Services

Method	Member services — Contact information
Call	**1-866-944-4983.** This call is free. 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept We have free interpreter services for people who don't speak English.
TTY	**711**. This call is free. 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept
Write	For general questions or concerns: UnitedHealthcare Community Plan PO Box 30769 Salt Lake City UT 84130-0769
Website	**UHCCommunityPlan.com**

Contact Member Services to get help with:

- questions about the plan
- questions about claims, billing, information or your UnitedHealthcare UCard
- coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of this **Member Handbook**.
- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of this **Member Handbook** or contact Member Services.
- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

  - You can call us and explain your complaint at **1-866-944-4983**.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can complain about your STAR+PLUS plan to the Texas Health and Human Services (HHS) Office of the Ombudsman at 877-787-8999 or by faxing 888-780-8099 or writing to:

    HHS Office of the Ombudsman
    PO Box 13247
    Austin, Texas 78711-3247
  - To learn more about making a complaint about your healthcare, refer to **Chapter 9** of this **Member Handbook**.
- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**
    - the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs.
  - STAR+PLUS will pay for wrap-around drugs/products for dual-eligible members after commercial insurance has been billed or if there's no commercial insurance on file. These drugs include nonprescription (over-the-counter) medications, some products used in symptomatic relief of cough and colds, and some prescription vitamins and mineral products.
  - For more on coverage decisions about your drugs, refer to **Chapter 9** of this **Member Handbook**.
- appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your drugs, refer to **Chapter 9** of this **Member Handbook**.
- complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above.)

  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your drugs, refer to **Chapter 9** of this **Member Handbook**.
- payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this **Member Handbook**.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this **Member Handbook**.

Section B Your Service Coordinator

Service coordination is a service UnitedHealthcare Community Plan gives you to help with your health and well-being. A Service Coordinator will review, plan and help you in meeting your health care coverage needs. To get in touch with a Service Coordinator, look on your UnitedHealthcare UCard for the phone number. You can also call Member Services at **1-866-944-4983** (TTY **711**), 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept to help you reach your Service Coordinator. Our goal is to find a Service Coordinator that is a good fit for your needs; but, if you want to change your Service Coordinator you can call Member Services at **1-866-944-4983** (TTY **711**), 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept.

Method	Service Coordinator — Contact information
Call	**1-866-944-4983**. This call is free. 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept We have free interpreter services for people who don't speak English.
TTY	**711**. This call is free. 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept
Write	UnitedHealthcare Community Plan P.O. Box 30769 Salt Lake City, UT 84130-0769

Contact your service coordinator to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about transportation
- questions about long-term services and supports
- questions about accessing community supports

Section C Health Information, Counseling, and Advocacy Program (HICAP)

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

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

Method	Health Information, Counseling, and Advocacy Program (HICAP) — Contact information
Call	800-252-9240 Monday-Friday 8:00 a.m. to 5:00 p.m. CST
TTY	1-512-424-6597
Write	Texas Department of Aging and Disability Services 701 West 51st Street, MC: W275 Austin, TX 78751
Email	AAA.help@hhsc.state.tx.us
Website	hhs.texas.gov/services/health/medicare

Contact HICAP for help with:

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

Section D Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)

Our state has an organization called Acentra. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Acentra is an independent organization. It's not connected with our plan.

Method	ACENTRA — Contact information
Call	888-315-0636
TTY	711
Write	5201 West Kennedy Blvd. Suite 900 Tampa, FL 33609
Website	www.acentraqio.com

Contact ACENTRA for help with:

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

Section E Medicare

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

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

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

Section F STAR+PLUS

STAR+PLUS is a Texas Medicaid-managed care program for adults who have disabilities or are age 65 or older and provides healthcare and long-term services and supports through our health plan.

You're enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call Texas Medicaid. Be sure to mention you're enrolled in a STAR+PLUS plan.

Method	STAR+PLUS — Contact information
Call	Texas Health and Human Services 877-541-7905 Monday–Friday, 8:00 a.m. to 6:00 p.m. CST
TTY	711
Write	Texas Health and Human Services P. O. Box 13247 Austin, TX 78711-3247
Website	www.yourtexasbenefits.com

Section G HHS Office of the Ombudsman

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

Method	HHS Office of the Ombudsman — Contact information
Call	877-787-8999 Monday–Friday, 8:00 a.m. to 5:00 p.m. CST
TTY	1-800-735-2989 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
Write	Texas Health and Human Services Office of the Ombudsman P.O. Box 13247 Austin, TX 78711-3247
Website	www.hhs.texas.gov/services/your-rights/hhs-office-ombudsman

Section H Texas Office of the Long-Term Care Ombudsman

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

Texas Office of the Long-Term Care Ombudsman isn't connected with our plan or any insurance company or health plan.

Method	Long-Term Care Ombudsman — Contact information
Call	800-252-2412 Monday–Friday, 8:00 a.m. to 5:00 p.m. CST
TTY	711
Write	HHS Office of the Ombudsman P.O. Box 13247 Austin, Texas 78711-3247
Email	ltc.ombudsman@hhs.texas.gov
Website	https://ltco.texas.gov/

Section I Programs to Help People Pay for Drugs

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

Section I1 Extra Help from Medicare

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

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

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help get evidence of your correct copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- Call Member Services at the number found at the bottom of this page.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at the number at the bottom of the page if you have questions.

Section I2 State Pharmaceutical Assistance Program (SPAP)

If you're enrolled in a SPAP, or any other program that provides coverage for Medicare Part D drugs other than "Extra Help" you still get the 70 percent discount on covered brand name drugs. Also, the plan pays five percent of the cost of brand drugs in the coverage gap. The 70 percent discount and the five percent paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

Section I3 AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible people living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the Texas HIV Medication Program.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of the state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to receive assistance for information on eligibility criteria, covered drugs, or how to enroll in the program, please call Texas HIV Medication Program at 800-255-1090.

Section I4 The Medicare Prescription Payment Plan

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

Section J Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

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

Section K Railroad Retirement Board (RRB)

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

Method	Railroad Retirement Board (RRB) — Contact information
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with a RRB representative from 9:00 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday. Press "1" to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number aren't free.
Website	www.rrb.gov

Section L Group insurance or other insurance from an employer

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

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

Chapter 3

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

Chapter 3

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

Introduction

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

Table of Contents

Section A Information about services and providers

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

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

Network providers are providers who work with our plan. These providers agree to accept our payment and your cost-sharing amount as full payment. We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing or only your share of the cost for covered services.

Section B Rules for getting services our plan covers

Our plan covers all services covered by Medicare and STAR+PLUS. This includes behavioral health and LTSS.

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

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this **Member Handbook**.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (for more information, go to **Section D1** of this chapter).
  - In most cases, your network PCP or our plan must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services.
  - Our plan's PCPs may be affiliated with medical groups. When you choose your PCP, you're also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is a doctor group practice, advance practice nurse, or advance practice nurse group who is picked by

you to give you or coordinate your covered services. Regular checkups with your PCP are important and can help you stay healthy. Your PCP will do regular health screenings that can help find problems. Finding and treating problems early might keep them from becoming bigger problems later. Your PCP will be your main doctor from now on. Your PCP will take care of you and refer you to a specialist when needed. You should talk to your PCP about all of your health care needs.

  - You don't need referrals from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, go to **Section D1** in this chapter).

- **You must get your care from network providers** (for more information, go to **Section D** in this chapter). Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, go to **Section I** in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. Authorization may be required before seeking care. In this situation, we cover the care as if you got it from a network provider. For information about getting approval to use an out-of-network provider, go to **Section D4** in this chapter.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. The cost-sharing you pay for dialysis can never be higher than the cost-sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside the plan's network, your cost-sharing can't be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from an out-of-network provider, your cost-sharing for the dialysis may be higher. If possible, call Member Services at the number at the bottom of the page before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

While you are a member of our Point of Service (POS) plan you may use either network providers or out-of-network providers for covered routine dental services.

Section C Your service coordinator

Section C1 What a service coordinator is

A service coordinator is a trained person who works for our plan to provide care coordination services for you.

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

Section C2 How you can contact your service coordinator

To talk to your Service Coordinator, look on your UnitedHealthcare UCard for the phone number. You can also call Member Services at the number found at the bottom of the page to help you reach your Service Coordinator.

We have free interpreter services for people who do not speak English.

Section C3 How you can change your service coordinator

Our goal is to find a Service Coordinator that is a good fit for your needs; but, if you want to change your Service Coordinator you can call Member Services at the number found at the bottom of the page.

Section D Care from providers

Section D1 Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care. Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you're also choosing the affiliated medical group.

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

A Primary Care Provider (PCP) is a licensed network doctor, doctor group practice, advance practice nurse, or advance practice nurse group who is picked by you to give you or coordinate your covered services. Regular checkups with your PCP are important and can help you stay healthy. Your PCP will do regular health screenings that can help find problems. Finding and treating problems early might keep them from becoming bigger problems later. Your PCP will be your main doctor from now on. Your PCP will take care of you and refer you to a specialist when needed. You should talk to your PCP about all of your health care needs.

Always talk to your PCP when you want to visit another doctor. Your PCP will give you a referral form if you need one. Your relationship with your PCP is important. Get to know your PCP as soon as possible. It is important to follow your PCP's advice. A good way to build a relationship with your PCP is to call and schedule a checkup. You can meet your PCP then. They will get to know your medical history, any medications you are taking and any other health problems.

The role of your PCP

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

Your choice of PCP

If there's a particular specialist or hospital that you want to use, find out if they're affiliated with your PCP's medical group. You can look in the **Provider and Pharmacy Directory** or ask Member Services to find out if the PCP you want makes referrals to that specialist or uses that hospital.

Option to change your PCP

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

If you want to change your PCP, call Member Services. PCP changes within the first month of being a member will start on the date you asked for it. If you request a PCP change after your first month of being a member, the change will start on the first day of the next month. You will get a new UnitedHealthcare UCard that shows your new PCP name and phone number.

Our plan's PCPs may be affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for a change, tell Member Services if you use a specialist or get other covered services that must have PCP approval. Member Services helps you continue your specialty care and other services when you change your PCP.

Services you can get without approval from your PCP

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers
- Urgently needed covered services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if 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 network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccines, as well as hepatitis B vaccines and pneumonia vaccines as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.

Section D2 Care from specialists and other network providers

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

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

When you and your PCP agree you need to go to another doctor (specialist), your provider will recommend someone for you to see. You will need a referral from your PCP to see a network specialist or behavioral/mental health provider. Your PCP can recommend a network specialist for your medical condition, answer questions you have about a network specialist's treatment plan and give follow-up health care as needed. For coordination of care, we ask you to tell your PCP and your Service Coordinator when you see a network specialist. We will help the prior authorization team get any approvals needed for your covered services or drugs.

Please look in the **Provider and Pharmacy Directory** for a list of plan specialists in your network, or you can check the **Provider and Pharmacy Directory** online at the website listed in **Chapter 2** of this booklet.

Section D3 When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past three years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.

- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization may be required.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

Section D4 Out-of-network providers

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

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

Section E Long-term services and supports (LTSS)

UHC Dual Complete® covers all services covered by Medicare and Texas Medicaid. This includes behavioral health and long-term services and supports (LTSS).

UHC Dual Complete® will generally pay for the health care and services you get if you follow plan rules. To be covered by our plan:

- **The care you get must be a plan benefit.** This means that it must be included in the plan's Benefits Chart. (The chart is in **Chapter 4** of this handbook).
- **The care must be medically necessary.** Medically necessary means reasonable and necessary to prevent or treat illnesses or health conditions or disabilities. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, equipment or drugs meet accepted standards of medical practice.
- **You must have a network primary care provider (PCP) who has ordered the care or has told you to use another doctor. As a plan member, you must choose a network provider to be your PCP.**

- In most cases, our plan must give you approval before you can use someone that is not your PCP or use other providers in the plan's network. This is called a **referral**. If you don't get approval, UHC Dual Complete TX-Y1 (HMO-POS D-SNP) may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. To learn more about referrals, refer to **Chapters 3 and 4**.
- You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP.
- **Note:** In your first 90 days with our plan, you may continue to use your current providers, at no cost, if they are not a part of our network. During the 90 days, our Service Coordinator will contact you to help you find providers in our network. After 90 days, we will no longer cover your care if you continue to use out-of-network providers.

- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
  - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out what emergency or urgently needed care means, refer to **Section I**.
  - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. Please talk to your Service Coordinator to get an approval before you get this care. In this situation, we will cover the care as if you got it from a network provider. To learn about getting approval to use an out-of-network provider, refer to **Section D4**.
  - The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility.
  - When you first join the plan, you can continue using the providers you use now for at least 90 days.

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

We cover medically necessary behavioral health services. If you have a drug problem or are very upset about something, you can get help. Call **1-800-690-1606**, TTY **711** for help. You do not need a referral for these services.

There will be people who can speak with you in English or Spanish. If you need help with other languages, please tell them. Member Services will connect you to the Language Line and answer your questions. Please call TTY **711**, for hearing impaired.

If it is a crisis and you have trouble with the phone line, call **911** or go to the nearest emergency room and call UHC Dual Complete® within 24 hours.

Section G How to get Consumer Directed Services

Section G1 Consumer Directed Services (CDS) allows people to hire and manage people who provide their services

Consumer directed care recognizes that the individual is knowledgeable about his or her own care needs, and the individual is empowered and accountable for his or her own care; and places an emphasis on environmental change and quality of life. Consumer directed care emphasizes the ability of you, as a consumer, to:

- Advocate for your own needs
- To make choices about what services would best meet those needs
- To monitor the quality of those services

Section G2 Who can get Consumer directed care (for example, if it's limited to waiver populations)

You can visit the CDS website at www.hhs.texas.gov/providers/long-term-care-providers/consumer-directed-services-cds. Here, you can read more about the CDS option. You can also see a list of consumer directed services agencies, and contact them to find out more about the CDS option and how it works.

Section H Non-Emergency Medical Transportation (NEMT) services

Please refer to **Chapter 4** for more information about benefit limitations.

Section H1 What NEMT Services are

NEMT Services provide transportation to nonemergency health care appointments if you have no other transportation options.

- These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get health care services.

- These trips **don't** include ambulance trips.

Section H2 What services are included

NEMT Services include:

- Passes or tickets for transportation, such as mass transit within and between cities or states (including by rail or bus).
- Commercial airline transportation services.
- Demand response (curb-to-curb) transportation services in private buses, vans, or sedans (including wheelchair-accessible vehicles, if necessary).
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor.
- Transportation costs for your NEMT attendant if you need them to travel to your appointment with you. An NEMT attendant is:
  - An adult providing necessary mobility or personal or language assistance to you during transportation. (For example, this can include an adult serving as your personal attendant.)
  - A service animal providing necessary mobility or personal assistance to you during transportation and that occupies a seat that would otherwise be filled by another person.
  - An adult traveling with you because a health care provider has stated in writing that you require an attendant.

Section H3 How to schedule NEMT Services

Remember to schedule rides as early as possible, and **at least two business days before you need the ride**. You may schedule rides with less notice in certain cases, including:

- Pickup after a hospital discharge.
- Trips to the pharmacy for medication or approved medical supplies.
- Trips for urgent conditions. (An urgent condition is a health condition that isn't an emergency but is severe or painful enough to require treatment within 24 hours.)

Schedule rides for long-distance trips at least five days in advance.

If you have a scheduled ride and your health care appointment is cancelled **before** the trip, contact SafeRide at 888-617-0382, TTY 711, 8 a.m.–5 p.m. local time, Monday–Friday right away.

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

Section I1 Care in a medical emergency

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

- serious risk to your life and if you're pregnant, loss of an unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**
- in the case of a pregnant woman in active labor, when:
  - There isn't enough time to safely transfer you to another hospital before delivery.
  - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, tell us about your emergency.** We follow up on your emergency care. You or someone else should call Member Services at the number found at the bottom of this page to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of this **Member Handbook**.

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

When you receive emergency care in the United States, after the emergency is over you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to

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

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

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

Getting emergency care if it wasn't an emergency

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

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

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

Section I2 Urgently needed care

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

Urgently needed care in our plan's service area

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

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

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

You can find a list of the contracted Urgent Care Centers in the **Provider and Pharmacy Directory** or call Member Services at the phone number found at the bottom of this page. If you do not know whether you need to visit an urgent care center, you can call our 24/7 NurseLine services at 1-877-839-5407 (TTY 711) and our NurseLine Representative will help you. Don't forget to tell your PCP about any visits to an urgent care center. By doing this, your PCP can help coordinate your health care.

Urgently needed care outside our plan's service area

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

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

Section I3 Care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the president of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit our website found at the bottom of this page for information on how to get care you need during a declared disaster.

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

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

If you paid more than your plan cost-sharing for covered services or if you got a bill for the full cost of covered medical services, refer to **Chapter 7** of this **Member Handbook** to find out what to do.

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

Section J1 What to do if our plan doesn't cover services

If you believe that you should be reimbursed for Texas Medicaid-covered benefits that you already paid for, please call Member Services for help.

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of this **Member Handbook**), **and**

- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself**.

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

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

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

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

Section K1 Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

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

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

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

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

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

- room and board for a hospital stay that Medicare would pay for even if you weren't in a study

- an operation or other medical procedure that's part of the research study
- treatment of any side effects and complications of the new care

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

Section K3 More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf).You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

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

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

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

Section L2 Care from a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.

– You must get approval from us before you're admitted to the facility, or your stay **won't** be covered.

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

Section M Durable medical equipment (DME)

Section M1 DME as a member of our plan

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

You always own some DME items, such as prosthetics.

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

In some limited situations, we transfer ownership of the DME item to you. Call Member Services at the phone number at the bottom of the page for more information.

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

Section M2 DME ownership if you switch to Original Medicare

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

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

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

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

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

Section M3 Oxygen equipment benefits as a member of our plan

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

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

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

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

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

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

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

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

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

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

Chapter 4

Benefits chart

Chapter 4

Benefits chart

Introduction

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

Table of Contents

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

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

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

If you need help understanding what services are covered, call your service coordinator and/or Member Services at the phone number found at the bottom of this page.

Section B Rules against providers charging you for services

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

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

Section C About our plan's Benefits Chart

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

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

- We provide covered Medicare STAR+PLUS covered services according to the rules set by Medicare and STAR+PLUS.
- The services (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs) must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.

- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed care, or unless your plan or a network provider gave you a referral. **Chapter 3** of this **Member Handbook** has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a referral. **Chapter 3** of this **Member Handbook** has more information about getting a referral and when you don't need one.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA in italic type.
- If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.

Important Benefit Information for Members with Certain Chronic Conditions.

If you have any of the chronic condition(s) listed below and meet certain medical criteria, you may be eligible for additional benefits and/or reduced cost-sharing:

- Diabetes mellitus (type 1 or type 2)
- Cardiovascular disorders
- Chronic heart failure
- Chronic hypertension (chronic high blood pressure)
- Chronic hyperlipidemia (chronic high cholesterol)
- Autoimmune disorders
- Cancer
- Chronic alcohol use disorder and other substance use disorders (SUDs)
- Chronic gastrointestinal disease
- Chronic kidney disease (CKD)
- Chronic lung disorders
- Chronic and disabling mental health conditions
- Dementia
- HIV/AIDS
- Immunodeficiency and immunosuppressive disorders

- Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
- Neurologic disorders
- Overweight, obesity and metabolic syndrome
- Post-organ transplantation care
- Severe hematologic disorders
- Stroke
- Conditions associated with cognitive impairment
- Conditions with functional challenges and require similar services

Covered items include:

- Healthy foods like fruits, vegetables, meat, seafood, dairy products, water and more.
- Eligible utility bills like electricity, home heat like natural gas, water and home internet. The service address must match an address we have on file for you.

You can use your credit at thousands of participating stores or place an order online. Home shipping is free and there is a $35 minimum to place an order. Taxes may apply.

Visit the UCard Hub to learn more about using your benefit, check your balance, find covered products, locate participating stores and more.

All Medicare-covered preventive services are free. This apple shows the preventive services in the Benefits Chart.

Section D Our plan's Benefits Chart

Services that our plan pays for	What you must pay
Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0

Services that our plan pays for	What you must pay
Acupuncture We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. **Generally, Medicare-covered acupuncture services are not covered when provided by an acupuncturist or chiropractor.** Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. **This benefit is continued on the next page.**	$0 Your provider may need to obtain prior authorization. Referral is required.

Services that our plan pays for	What you must pay
Acupuncture (continued) Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. Acupuncture services performed by providers that do not meet CMS acupuncture provider requirements are not covered even in locations where there are no providers available that meet CMS requirements.	
Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	$0

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

Services that our plan pays for	What you must pay
Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Welcome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	$0
Behavioral health services The plan will pay for the following services: • mental health targeted case management • mental health rehabilitative services – outpatient mental health care We pay for behavioral health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws	$0
Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0

Services that our plan pays for	What you must pay
Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women aged 40 and older • clinical breast exams once every 24 months	$0
Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's referral. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0 Your provider may need to obtain prior authorization. Referral is required.
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you're eating well.	$0
Cardiovascular (heart) disease screening tests We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0

Services that our plan pays for	What you must pay
Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • for women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months • for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months	$0
Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment • Excluded from Medicare coverage is any service other than manual manipulation for the treatment of subluxation.	$0 Your provider may need to obtain prior authorization.
Chronic care management services, including chronic pain management and treatment plan services If you have serious chronic conditions and receive chronic care management services, your provider develops a monthly comprehensive care plan that lists your health problems and goals, providers, medications, community services you have and need, and other information about your health. Your provider also helps coordinate your care when you go from one health care setting to another. **This benefit is continued on the next page.**	For your monthly chronic care management plan, you will pay the cost-sharing that applies to primary care services or specialist physician services (as described under "Physician/ practitioner services, including doctor's office visits") depending on the type of provider who developed your plan. Referral may be required.

Services that our plan pays for	What you must pay
Chronic care management services, including chronic pain management and treatment plan services (continued)	For any care recommended under your plan, you will pay the applicable cost-sharing. Services recommended under chronic pain management plans may include (but are not limited to) primary care services, specialist physician services, physical therapy, occupational therapy, lab or diagnostic tests, or prescription drugs (as described under "Physician/practitioner services, including doctor's office visits", "Outpatient rehabilitation services", "Outpatient diagnostic tests and therapeutic services and supplies", or "Medicare Part B Drugs", or see Chapter 6 for what you pay for applicable Part D drugs). Referral may be required.

Services that our plan pays for	What you must pay
Colorectal cancer screening The plan will pay for the following services: • Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonsocopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. **This benefit is continued on the next page**	$0 There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes an outpatient diagnostic colonoscopy.

Services that our plan pays for	What you must pay
Colorectal cancer screening (continued) • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services Certain dental services, including cleanings, fillings, and dentures, are available through the Texas Medicaid Dental Program. We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.	$0 copayment for Medicare-covered dental services. $2,500 dental allowance for covered services like cleanings, fillings, x-rays and crowns. Your provider may need to obtain prior authorization.
Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	$0
Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	$0

Services that our plan pays for	What you must pay
Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: – a blood glucose monitor – blood glucose test strips – lancet devices and lancets – glucose-control solutions for checking the accuracy of test strips and monitors – You can get certain continuous glucose monitors (CGMs) from your pharmacy, and all are available from a DME provider at the same cost. If you have Type 1 diabetes, you don't need prior authorization. For Type 2 diabetes and other conditions, you will need a prior authorization for CGMs from a DME provider. Prior authorizations for CGMs and supplies are approved for 12 months. Or you can get certain CGMs from a pharmacy without prior authorization if your claim history includes insulin or any type of CGM device part (ex. sensors, transmitters). – For details on Medicare's CGM requirements, visit medicare.gov/coverage/therapeutic-continuous-glucose-monitors. • For people with diabetes who have severe diabetic foot disease, we pay for the following: – one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** – one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services. **This benefit is continued on the next page**	$0 for each Medicare-covered continuous glucose monitor (CGM) and supplies with an approved prior authorization. There are no brand limitations for CGMs. May require your provider to get prior authorization from the plan for in-network benefits. We only cover Contour® and Accu-Chek® brands. Other brands are not covered by your plan. Covered glucose monitors include: Contour Plus Blue, Contour Next EZ, Contour Next Gen, Contour Next One, Accu-Chek Guide Me and Accu-Chek Guide. Test strips: Contour, Contour Plus, Contour Next, Accu-Chek Guide and Accu-Chek Aviva Plus.

Services that our plan pays for	What you must pay
Diabetic self-management training, services, and supplies (continued) • Diabetes self-management training is covered under certain conditions. Limited to 20 visits of 30 minutes per year for a maximum of 10 hours the initial year. Followup training subsequent years after, limited to 4 visits of 30 minutes for a maximum of 2 hours per year. We cover the blood glucose monitors and test strips in this list. We don't usually cover other brands unless your provider tells us it's medically necessary. If you're new to the plan and using a brand that isn't on our list, you can request a temporary supply within the first 90 days of enrollment while you talk with your provider. They can help you decide if any of the preferred brands work for you. If you or your provider think it's medically necessary for you to keep using a different brand, you can request a coverage exception to have it covered for the rest of the plan year. After the first 90 days of enrollment, non-preferred products will only be covered with an approved exception. If you (or your provider) don't agree with the plan's coverage decision, you or your provider can file an appeal. You can also file an appeal if you don't agree with your provider's decision about the appropriate product or brand for your condition. (For more information about appeals, see Chapter 9.)	

Services that our plan pays for	What you must pay
Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of this **Member Handbook** for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area doesn't carry a particular brand or maker, you may ask them if they can special order it for you. With this **Member Handbook**, we sent you our plan's list of DME. The list tells you the brands and makers of DME that we pay for. You can also find the most recent list of brands, makers, and suppliers on our website found at the bottom of this page. **This benefit is continued on the next page**	$0 copayment for Medicare-covered benefits. Your provider may need to request prior authorization. Your cost sharing for Medicare oxygen equipment coverage is $0 copayment, every time you get covered equipment or supplies. Your provider may need to request prior authorization. Your cost sharing won't change after you're enrolled for 36 months. If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in our plan, your cost sharing in our plan is $0 copayment. Your provider may need to request prior authorization.

Services that our plan pays for	What you must pay
Durable medical equipment (DME) and related supplies (continued) Generally, our plan covers any DME covered by Medicare and STAR+PLUS from the brands and makers on this list. We don't cover other brands and makers unless your doctor or other provider tells us that you need the brand. If you're new to our plan and using a brand of DME not on our list, we'll continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.) If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor can file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is appropriate for your medical condition. For more information about appeals, refer to **Chapter 9** of this **Member Handbook**.	

Services that our plan pays for	What you must pay
Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to evaluate or treat a medical emergency. A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your life or to that of your unborn child; **or** • serious harm to bodily functions; **or** • loss of a limb, or loss of function of a limb. • In the case of a pregnant woman in active labor, when: – There isn't enough time to safely transfer you to another hospital before delivery. – A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. Worldwide coverage for emergency department services outside of the United States. • This includes emergency or urgently needed care and emergency ambulance transportation from the scene of an emergency to the nearest medical treatment facility. • Transportation back to the United States from another country is not covered. • Pre-scheduled, pre-planned treatments (including dialysis for an ongoing condition) and/or elective procedures are not covered. • Services provided by a dentist are not covered. • Provider access fees, appointment fees and administrative fees are not covered. **This benefit is continued on the next page**	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must move to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay. Outside the United States: $0 copayment for worldwide coverage for emergency services outside of the United States. In most cases you will pre-pay the foreign provider for the service and request reimbursement. Please see Chapter 7 for expense reimbursement for worldwide emergency services.

Services that our plan pays for	What you must pay
Emergency care (continued) • Generally, you will pay the full cost of emergency services received outside of the United States at the time you receive services and then will request reimbursement from us. Payment requests we receive from intermediaries, claims management companies or third-party billers for services received outside of the United States are not reimbursable.	
Fitness program Your fitness program helps you stay active and connected at the gym, from home or in your community. It's available to you at no cost and includes: • Free gym membership at core locations • Access to a large national network of gyms and fitness locations • On-demand workout videos and live streaming fitness classes • Online memory fitness activities See Chapter 11 for the fitness program terms and conditions of coverage. You can get more information by viewing the Vendor Information Sheet at **myUHC.com/CommunityPlan** or by calling Member Services to have a paper copy sent to you.	$0 A home-delivered fitness kit is available if you live 15 miles or more from a network gym or fitness location. Coverage is limited to in-network locations only.

Services that our plan pays for	What you must pay
Family planning services The law lets you choose any provider — whether a network provider or out-of-network provider — for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	$0

Services that our plan pays for	What you must pay
Health and wellness education programs These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness and stress management.	$0
Hearing services Once per year, we pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	$0 copayment for each Medicare-covered exam.
Hearing Services — Hearing Aids Through UnitedHealthcare Hearing, you can choose from a broad selection of over-the-counter (OTC) and prescription hearing aids. This includes brand-name manufacturers, as well as Relate®, UnitedHealthcare Hearing's private-label brand that offers affordable, high-quality hearing aids with a variety of technology options and helpful features. Hearing aids can be fit in-person with a network provider or delivered directly to you (select products only). This benefit is limited to 2 hearing aids every 2 years. Hearing aid accessories, additional batteries and optional services are available for purchase, but they are not covered by the plan. You can get more information by viewing the Vendor Information Sheet at **myUHC.com/CommunityPlan** or by calling Member Services to have a paper copy sent to you. Hearing aids purchased outside of UnitedHealthcare Hearing are not covered.	$0 Provided by: UnitedHealthcare Hearing Hearing aid allowance is $2,200 Contact UnitedHealthcare Hearing to access your hearing aid benefit and get connected with a network provider. You must obtain prior authorization from UnitedHealthcare Hearing. Additional fees may apply for optional follow-up visits. Home-delivered hearing aids are available nationwide through UnitedHealthcare Hearing (select products only). Hearing aids purchased outside of UnitedHealthcare Hearing are not covered.

Services that our plan pays for	What you must pay
HIV screening We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. If you're pregnant, we pay for up to three HIV screening tests during a pregnancy.	$0
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies	$0 copayment for all home health visits provided by a network home health agency when Medicare criteria are met. Your provider may need to request prior authorization. Other copayments or coinsurance may apply (Please see Durable medical equipment and related supplies for applicable copayments or coinsurance). Referral is required.

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

Services that our plan pays for	What you must pay
Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare:** • Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay our plan's cost-sharing amount for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of this **Member Handbook**. **This benefit is continued on the next page**	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not UHC Dual Complete TX-Y1 (HMO-POS D-SNP).

Services that our plan pays for	What you must pay
Hospice care (continued) **Note:** If you need non-hospice care, call your service coordinator and/or member services to arrange the services. Non-hospice care is care that **isn't** related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill member who hasn't chosen the hospice benefit.	
Immunizations We pay for the following services: • pneumonia vaccines • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you're at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you're at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this **Member Handbook** to learn more.	$0 There is no coinsurance, copayment, or deductible for the pneumonia, flu, Hepatitis B, or COVID-19 vaccines. There is no coinsurance, copayment, or deductible for all other Medicare-covered immunizations.

Services that our plan pays for	What you must pay
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • blood, including storage and administration • physician services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. **This benefit is continued on the next page**	$0 copayment for each Medicare-covered hospital stay for unlimited days each time you are admitted. Your provider may need to request prior authorization. *Referral is required*. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you'd pay at a network hospital. Medicare hospital benefit periods do not apply. (See definition of benefit periods in the chapter titled Definitions of important words.) For inpatient hospital care, the cost-sharing described above applies each time you are admitted to the hospital. You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.

Services that our plan pays for	What you must pay
Inpatient hospital care (continued) If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. The plan has a network of facilities that perform organ transplants. The plan's hospital network for organ transplant services is different than the network shown in the "Hospitals" section of your provider directory. Some hospitals in the plan's network for other medical services are not in the plan's network for transplant services. For information on network facilities for transplant services, contact Member Services. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet **Medicare Hospital Benefits**. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	A transfer to a separate facility type (such as an Inpatient Rehabilitation Hospital or Long-Term Care Hospital) is considered a new admission. For each inpatient hospital stay, you are covered for unlimited days as long as the hospital stay is covered in accordance with plan rules.

Services that our plan pays for	What you must pay
Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay for members under age 21 or ages 65 and older. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. • Inpatient substance abuse services	$0 copayment up to 90 days per benefit period, plus an additional 60 lifetime reserve days. Your provider may need to request prior authorization. Medicare hospital benefit periods are used to determine the total number of days covered for inpatient mental health care. (See definition of benefit periods in the chapter titled Definitions of important words.) However, the cost-sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times within a benefit period.

Services that our plan pays for	What you must pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We don't pay for your inpatient stay if the stay isn't reasonable and medically necessary. However, in certain situations where inpatient care isn't covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services. We pay for the following services, and maybe other services not listed here: • doctor services • diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • surgical dressings • splints, casts, and other devices used for fractures and dislocations • prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: – an internal body organ (including contiguous tissue), **or** – the function of an inoperative or malfunctioning internal body organ. • leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition • physical therapy, speech therapy, and occupational therapy	$0 When your stay is no longer covered, these services will be covered as described in the following sections: Please refer below to Physician/practitioner services, including doctor's office visits. Please refer below to Outpatient diagnostic tests and therapeutic services and supplies Please refer below to Prosthetic and orthotic devices and related supplies. Please refer below to Outpatient rehabilitation services.

Services that our plan pays for	What you must pay
Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this **Member Handbook**, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B pays for some drugs for dialysis. For information, refer to "Medicare Part B drugs" in this chart.	$0 Referral may be required. Prior authorization may be required.

Services that our plan pays for	What you must pay
Lung cancer screening with low dose computed tomography (LDCT) Our plan pays for lung cancer screening every 12 months if you: • are aged 50–77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	$0
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	$0
Medicare Diabetes Prevention Program (MDPP) Our plan pays for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0

Services that our plan pays for	What you must pay
Medicare Part B drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • the Alzheimer's drug Leqembi® (generic lecanemab) which is given intravenously (IV) • clotting factors you give yourself by injection if you have hemophilia • transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself • some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug.) As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does **This benefit is continued on the next page**	$0 Prior authorization may be required.

Services that our plan pays for	What you must pay
Medicare Part B drugs (continued) • oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics • erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epotin beta) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) • Chemotherapy Drugs, and the administration of chemotherapy drugs We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **Chapter 5** of this **Member Handbook** explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this **Member Handbook** explains what you pay for your drugs through our plan.	

Services that our plan pays for	What you must pay
Routine transportation Details of this benefit: • Up to 36 one-way trips are covered each year (limited to ground transportation only). • You are responsible for any costs over the trip limit. • Trips must be to or from plan-approved locations, such as network providers, medical facilities, pharmacies, gyms, or hearing and vision appointments. • Each one-way trip must not exceed 50 miles of driving distance. A trip is one-way transportation; a round trip is 2 trips. • Transportation services must be requested 2 business days prior to a routine scheduled appointment. • One companion is allowed per trip (companion must be at least 18 years old). • On some trips, you may have to share a ride with other transportation clients. • Trips are curb-to-curb service. • Wheelchair-accessible vans are available upon request. • Drivers do not have medical training. In case of emergency, call 911. This benefit does not cover transportation by: • Stretcher • Ambulance You can get more information by viewing the Vendor Information Sheet at myUHC.com/CommunityPlan or by calling Member Services to have a paper copy sent to you.	$0

Services that our plan pays for	What you must pay
Nursing facility care A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Services that we pay for include, but aren't limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • blood, including storage and administration • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services **This benefit is continued on the next page**	Prior authorization may be required.

Services that our plan pays for	What you must pay
Nursing facility care (continued) You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0
Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0 Your provider may need to obtain prior authorization.

Services that our plan pays for	What you must pay
Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition • other outpatient diagnostic tests	$0 Your provider may need to obtain prior authorization.
Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff. Get more information in the Medicare fact sheet **Medicare Hospital Benefits**. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf	$0 Your provider may need to obtain prior authorization.

Services that our plan pays for	What you must pay
Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services – Observation services help your doctor know if you need to be admitted to the hospital as "inpatient." – Sometimes you can be in the hospital overnight and still be "outpatient." – You can get more information about being inpatient or outpatient in this fact sheet: es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf. • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself **This benefit is continued on the next page**	$0 Your provider may need to obtain prior authorization.

Services that our plan pays for	What you must pay
Outpatient hospital services (continued) For the drug that is infused, you will pay the cost-sharing as described in "Medicare Part B Prescription Drugs" in this benefit chart. In addition, for the administration of infusion therapy drugs, you will pay the cost-sharing that applies to primary care provider services, specialist services, or outpatient hospital services (as described under "Physician/Practitioner Services, Including Doctor's Office Visits" or "Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers" in this benefit chart) depending on where you received drug administration or infusion services. Please refer to Medicare Part B Prescription Drugs and Physician/Practitioner Services, Including Doctor's Office Visits or Outpatient Surgery and Other Medical Services Provided at Hospital Outpatient Facilities and Ambulatory Surgical Centers. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." This is called an "Outpatient Observation" stay. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0 Prior authorization/referral may be required.

Services that our plan pays for	What you must pay
Outpatient substance use disorder services We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment	$0 Your provider may need to obtain prior authorization.
Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient.	$0 Prior authorization/referral may be required.

Services that our plan pays for	What you must pay
Over-the-counter (OTC) credit With this benefit, you'll get a credit loaded to your UCard each month to buy covered OTC items. Unused credit expires at the end of each month. Covered items include brand name and generic OTC products like vitamins, pain relievers, bladder control pads and first aid products. The credit cannot be used to buy tobacco or alcohol.	Monthly credit is $185
Home and bath safety devices You can also use your OTC credit on covered home and bath safety devices like bathmats, grab bars and shower chairs.	Combined with OTC credit amount
Fitness equipment You can use your OTC credit on covered fitness equipment like fitness mats, exercise machines or handheld weights, and wearable devices or activity trackers.	Combined with OTC credit amount
Support services You can also use your OTC credit on covered in-home support services such as respite care, non-skilled in-home care, and weight management services.	Combined with OTC credit amount
Healthy food and utilities - Special Supplemental Benefits for the Chronically Ill (SSBCI) If you qualify, healthy food and utilities will be included as part of your OTC credit expiring monthly. Your eligibility for healthy food and utilities is determined after you enroll in this plan. You must have at least one of the following chronic conditions to qualify: • Diabetes mellitus (type 1 or type 2) • Cardiovascular disorders • Chronic heart failure • Chronic hypertension (chronic high blood pressure) • Chronic hyperlipidemia (chronic high cholesterol) • Autoimmune disorders • Cancer **This benefit is continued on the next page**	Combined with OTC credit amount

Services that our plan pays for	What you must pay
Over-the-counter (OTC) credit (continued) • Chronic alcohol use disorder and other substance use disorders (SUDs) • Chronic gastrointestinal disease • Chronic kidney disease (CKD) • Chronic lung disorders • Chronic and disabling mental health conditions • Dementia • HIV/AIDS • Immunodeficiency and immunosuppressive disorders • Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy • Neurologic disorders • Overweight, obesity and metabolic syndrome • Post-organ transplantation care • Severe hematologic disorders • Stroke • Conditions associated with cognitive impairment • Conditions with functional challenges and require similar services Covered items include: • Healthy foods like fruits, vegetables, meat, seafood, dairy products, water and more. • Eligible utility bills like electricity, home heat like natural gas, water and home internet. The service address must match an address we have on file for you. You can use your credit at thousands of participating stores or place an order online. Home shipping is free and there is a $35 minimum to place an order. Taxes may apply. **This benefit is continued on the next page**	

Services that our plan pays for	What you must pay
Over-the-counter (OTC) credit (continued) Visit the UCard Hub to learn more about using your benefit, check your balance, find covered products, locate participating stores and more.	
Partial hospitalization services and intensive outpatient services **Partial hospitalization** is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	$0 Your provider may need to obtain prior authorization.

Services that our plan pays for	What you must pay
Personal care attendant services The plan covers personal assistance with activities of daily living. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • grooming • eating • bathing • dressing and personal hygiene • functional living tasks / assistance with planning • preparing meals • transportation, or assistance in securing transportation • assistance with ambulation and mobility • reinforcement of behavioral support or specialized therapies activities; **and** • assistance with medications These services can be self-directed if you choose. This option allows you or your legally authorized representative to be the employer of some of your service providers and to direct the delivery of program services.	$0

Services that our plan pays for	What you must pay
Physician/practitioner services, including doctor's office visits We pay for the following services: • medically necessary health care or surgery services given in places such as: • physician's office • certified ambulatory surgical center • hospital outpatient department • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your specialist, if your doctor orders them to find out whether you need treatment • certain telehealth services, including Urgently Needed Services, Primary Care Physician Services, Physician Specialist Services, Individual Sessions for Mental Health Specialty Services, Individual Sessions for Psychiatric Services, and Individual Sessions for Outpatient Substance Abuse. – You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare. • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder **This benefit is continued on the next page**	$0 Prior authorization/referral may be required.

Services that our plan pays for	What you must pay
Physician/practitioner services, including doctor's office visits (continued) • telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: – You have an in-person visit within 6 months prior to your first telehealth visit – You have an in-person visit every 12 months while receiving these telehealth services – Exceptions can be made to the above for certain circumstances • telehealth services for mental health visits provided by rural health clinics and federally qualified health centers. • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if** – you're not a new patient **and** – the check-in isn't related to an office visit in the past 7 days **and** – the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: – you're not a new patient **and** – the evaluation isn't related to an office visit in the past 7 days **and** – the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery • Monitoring services in a physician's office or outpatient hospital setting if you are taking anticoagulation medications, such as Coumadin, Heparin or Warfarin (these services may also be referred to as 'Coumadin Clinic' services).	$0 Prior authorization/referral may be required.

Services that our plan pays for	What you must pay
Podiatry services We pay for the following services: • 6 visits per year • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes	$0 Prior authorization/referral may be required.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	$0
Prostate cancer screening exams For men aged 50 and older, we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0

Services that our plan pays for	What you must pay
Prosthetic and orthotic devices and related supplies Prosthetic devices replace all or part of a body part or function. These include but aren't limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.	$0 Prior authorization/referral may be required.
Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have a referral for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0 Prior authorization/referral may be required.
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945–1965. If you were born between 1945–1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	$0

Services that our plan pays for	What you must pay
Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0

Services that our plan pays for	What you must pay
Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to **Chapter 12**. We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it's medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration – The plan will pay for whole blood and packed red cells beginning with the fourth pint of blood you need. You must pay for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. – The plan will pay for all other parts of blood beginning with the first pint used. • medical and surgical supplies given by SNFs • lab tests given by SNFs • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services A 3-day prior hospital stay is not required. You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	$0 Prior authorization/referral may be required. You are covered for up to 100 days each benefit period for inpatient services in a SNF, in accordance with Medicare guidelines. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Services that our plan pays for	What you must pay
Smoking and tobacco use cessation If you use tobacco, don't have signs or symptoms of tobacco-related disease, and want or need to quit: • We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.	$0
Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0

Services that our plan pays for	What you must pay
Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • an unforeseeen illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider beause given your time, place, or circumstances, it's not possible, or it's unreasonable to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). When outside of the United States and its territories, the plan covers emergency transportation to a nearby medical facility within the foreign country. Worldwide coverage for 'urgently needed services' when medical services are needed right away because of an illness, injury, or condition that you did not expect or anticipate, and you can't wait until you are back in our plan's service area to obtain services. Services provided by a dentist are not covered. Medical services performed out of the country aren't covered by Medicaid.	$0

Services that our plan pays for	What you must pay
Vision care We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes • African-Americans • Hispanic Americans For people with diabetes, we pay for screening for diabetic retinopathy once per year. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery. Covered eyeglasses after cataract surgery includes standard frames and lenses as defined by Medicare; any upgrades are not covered (including, but not limited to, deluxe frames, tinting, progressive lenses or anti-reflective coating).	$0 Your provider may need to obtain prior authorization.
Vision Care — Routine Eye Exam 1 routine eye exam (eye refraction) each year Eye refraction is part of the routine eye exam benefit. You can get more information by viewing the Vendor Information Sheet at **myUHC.com/CommunityPlan** or by calling Member Services to have a paper copy sent to you.	$0 Provided by: MARCH® Vision
Vision Care — Routine Eyewear • 1 Pair of lenses/frames and contact lenses every year You are responsible for any amount over the plan credit for eyewear. You can get more information by viewing the Vendor Information Sheet at **myUHC.com/CommunityPlan** or by calling Member Services to have a paper copy sent to you.	$0 Provided by: MARCH® Vision Plan pays up to $200 toward your purchase of lenses/frames and contact lenses.

Services that our plan pays for	What you must pay
“Welcome to Medicare” preventive visit We cover the one-time “Welcome to Medicare” preventive visit. The visit includes: • a review of your health, • education and counseling about preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.	$0

Section D1 Our home and community-based services

In addition to these general services, our plan also covers home and community-based services. These are services that you may be able to use instead of going to a facility. To get some of these services, you'll need to qualify for the home and community-based waiver (the STAR+PLUS Waiver). Your Service Coordinator will work with you to decide if these services are right for you and will be in your Plan of Care.

Community-based services that our plan covers	What you pay
Adaptive aids and medical supplies The plan covers the following devices, controls, appliances, or items that are necessary to address your specific needs, including those necessary for life support up to a $10,000 per year limit. The plan may pay for the following if medically or functionally necessary, and maybe other items/services not listed here: • lifts, including vehicle lifts • mobility aids • positioning devices • control switches/pneumatic switches and devices • environmental control units • medically necessary supplies • communication aids (including batteries) • adaptive/modified equipment for activities of daily living • safety restraints and safety devices Case managers can help you get medical supplies or equipment.	$0

Community-based services that our plan covers	What you pay
Adult foster care The plan covers 24-hour living arrangements in a foster home if you have physical, mental, or emotional limitations or if you're unable to continue functioning independently in your own home. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • meal preparation • housekeeping • personal care • nursing tasks • supervision • companion services • daily living assistance • transportation	$0

Community-based services that our plan covers	What you pay
Assisted living services The plan covers a 24-hour living arrangement for you if you're unable to live independently in your own home. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • Host home/companion care that provides you with: – personal assistance – functional living tasks – supervision of your safety and security – habilitation activities • Supervised living that provides you with: – personal assistance – functional living tasks – supervision of your safety and security – habilitation activities • Residential support service that provides you with: – personal assistance – functional living tasks	$0
Cognitive rehabilitation therapy The plan covers services that help you learn or re-learn cognitive skills. These skills may have been lost or altered as a result of damage to brain cells or brain chemistry.	$0
Day habilitation services • These services help you with obtaining, retaining, or improving skills necessary to live successfully at home and/or in community-based settings. • They promote independence, personal choice, and achievement of the outcomes identified in your service plan.	$0

Community-based services that our plan covers	What you pay
Dental services The plan covers the following services to help preserve your teeth and meet your medical needs up to $5,000 per year. If the services of an oral surgeon are required, you can get an additional $5,000 per year. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • emergency dental treatment • preventive dental treatment • therapeutic dental treatment (restoration, maintenance, etc.) • orthodontic dental treatment	$0
Emergency response services The plan covers emergency response services for you through an electronic monitoring system 24 hours a day, 7 days a week. In an emergency, you can press a call button to signal for help.	$0
Employment assistance The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • identifying your employment preferences, job skills, and requirements for a work setting and work conditions • locating prospective employers offering employment compatible with your identified preferences, skills, and requirements • contacting a prospective employer on your behalf and negotiating your employment • transportation • participating in service planning team meetings	$0

Community-based services that our plan covers	What you pay
Functional living task services These services help you with: • planning and preparing meals • transportation, or help in securing transportation • assistance with ambulation and mobility • reinforcement of behavioral support or specialized therapies activities • assistance with medications	$0
Home-Delivered meals The plan covers hot, nutritious meals that are served in your home. Meals are limited to 1 to 2 per day.	$0
Minor home modifications The plan covers minor home modifications to ensure your health, welfare, and safety and to allow you to function with greater independence in your home. The plan will cover up to $7,500 over the course of your lifetime and will also cover up to $300 each year for repairs. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • installation of ramps and grab bars • widening of doorways • modifications of kitchen and bathroom facilities, **and** • other specialized accessibility adaptations	$0
Nursing services The plan covers the treatment and monitoring of your medical conditions, especially if you have chronic conditions that require specific nursing tasks.	$0

Community-based services that our plan covers	What you pay
Occupational therapy The plan covers occupational therapy for you, which provides assessment and treatment by a licensed occupational therapist. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • screening and assessment • development of therapeutic treatment plans • direct therapeutic intervention • assistance, and training with adaptive aids and augmentative communication devices • consulting with and training other service providers and family members • participating on the service planning team, when appropriate	$0
Personal assistance services The plan covers personal assistance with activities of daily living. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • grooming • eating • bathing • dressing and personal hygiene • functional living tasks / assistance with planning • preparing meals • transportation or assistance in securing transportation • assistance with ambulation and mobility • reinforcement of behavioral support or specialized therapies activities; **and** • assistance with medications	$0

Community-based services that our plan covers	What you pay
Physical therapy The plan covers physical therapy, assessments, and treatments by a licensed physical therapist. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • screening and assessment • development of therapeutic treatment plans • direct therapeutic intervention • assistance and training with adaptive aids/augmentative communication devices • consulting with and training other service providers and family members • participating on the service planning team, when appropriate	$0 Your provider may need to obtain prior authorization.
Respite care The plan may pay for the following services if medically or functionally necessary up to 30 visits a year, and maybe other services not listed here: • personal assistance • habilitation activities • community activities • leisure activities • supervision of your safety and security • development of socially valued behaviors • development of daily living skills Respite care is provided to ensure your comfort, health, and safety. It may be provided in the following locations: your home or place of residence; adult foster care home; Texas Medicaid certified nursing facility; and an assisted living facility.	$0

Community-based services that our plan covers	What you pay
Speech, hearing, and language therapy The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • screening and assessment • development of therapeutic treatment plans • direct therapeutic intervention • assistance/training with adaptive aids and augmentative communication devices • consulting with and training other service providers and family members • participating on the service planning team, when appropriate	$0 Your provider may need to obtain prior authorization.
Support consultation The plan covers optional support consultation provided by a chosen certified support advisor. This advisor will assist you in learning about and performing employer responsibilities. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • recruiting, screening, and hiring workers • preparing job descriptions • verifying employment eligibility and qualifications, and other documents required to employ an individual • managing workers • other professional skills as needed	$0

Community-based services that our plan covers	What you pay
Supported employment The plan covers supported employment, which is provided to you at your place of employment if: • you need the support services to maintain employment due to a disability; • you're paid minimum wage (or more) for the work performed; **and** • your place of employment is competitive and integrated. The plan also covers transportation to and from your worksite, and supervision and training to you beyond what an employer would ordinarily provide.	$0
Transitional assistance services The plan covers one transition from a nursing facility to a home in the community, up to a $2,500 limit. The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here: • payment of security deposits required to lease an apartment or home • set-up fees or deposits to establish utility services for the home, including telephone, electricity, gas, and water • purchase of essential furnishings for the apartment or home, including table, chairs, window blinds, eating utensils, food preparation items, and bath linens • payment of moving expenses required to move into or occupy the home or apartment; **and** • payment for services to ensure your health in the apartment or home, such as pest eradication, allergen control, or a one-time cleaning before occupancy	$0

Section E Benefits covered outside of our plan

We don't cover the following services, but they're available through Medicare or Fee-For-Service. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Hospice programs provide members and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement. Your hospice doctor can be a network provider or an out-of-network provider.

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

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

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services and any Medicare Part A or B services. You pay nothing for these services.

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

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

For drugs that may be covered by UHC Dual Complete's Medicare Part D benefit:

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

Note: If you need non-hospice care, you should call your Service Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Your Service Coordinator can be reached at the phone number in Chapter 2 or you can call Member Services at the phone number on the bottom of this page.

Section F Benefits not covered by our plan, Medicare, STAR+PLUS, or Fee-For-Service Medicaid

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

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

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

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn't cover the following items and services:

- services considered not "reasonable and medically necessary", according Medicare and STAR+PLUS standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this **Member Handbook** for more information on clinical research studies. Experimental treatment and items are those that aren't generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- private duty nurses
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- routine foot care, except as described in Podiatry services in the Benefits Chart in Section D
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- regular hearing exams, hearing aids, or exams to fit hearing aids

- radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we'll reimburse the veteran for the difference. You're still responsible for your cost-sharing amounts.

Chapter 5

Getting your outpatient drugs

Chapter 5

Getting your outpatient drugs

Introduction

This chapter explains rules for getting your outpatient drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and STAR+PLUS. **Chapter 6** of this **Member Handbook** tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

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

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

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section.

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists.

You generally must use a network pharmacy to fill your prescription (Refer to **Section A1** for more information), or you can fill your prescription through the plan's mail-order service.

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

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

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

Your drug may require approval from our plan based on certain criteria before we'll cover it. (Refer to **Section C** in this chapter.)

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Section A Getting your prescriptions filled

Section A1 Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

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

Section A2 Using your UnitedHealthcare UCard when you fill a prescription

To fill your prescription, **show your UnitedHealthcare UCard** at your network pharmacy. The network pharmacy bills us for our share of the cost of your covered drug. You may need to pay the pharmacy a copay when you pick up your prescription.

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

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

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

Section A3 What to do if you change your network pharmacy

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

If you need help changing your network pharmacy, contact Member Services or your service coordinator.

Section A4 What to do if your pharmacy leaves the network

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

To find a new network pharmacy, refer to the **Provider and Pharmacy Directory**, visit our website, or contact Member Services or your service coordinator.

Section A5 Using a specialized pharmacy

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

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

Section A6 Using mail-order services to get your drugs

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition.

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

Filling prescriptions by mail

To get information about filling your prescriptions by mail, call Member Services at the number found at the bottom of the page.

Usually, a mail-order prescription arrives within 10 business days. However, sometimes your mail order may be delayed. If your mail order is delayed, please follow these steps:

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

Mail-order processes

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

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

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

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

   After the pharmacy gets a prescription from a health care provider, it contacts you to find out if you want the medication filled immediately or at a later time.

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

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

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

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

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

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

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

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

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

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

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

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

To opt out of our program that automatically prepares mail-order refills, contact us by calling Member Services.

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

Section A7 Getting a long-term supply of drugs

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

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 31-day supply has the same copay as a one-month supply. The **Provider and Pharmacy Directory** tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call your service coordinator or Member Services for more information.

You can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.

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

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

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

- Prescriptions for a Medical Emergency

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, and are included in our **Drug List**. Any restrictions will still apply.

- Coverage when traveling or out of the service area

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

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

Section A9 Paying you back for a prescription

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

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

Section B Our plan's Drug List

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

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

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

Section B1 Drugs on our Drug List

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

Certain drugs may be covered for some medical conditions but considered non-formulary for other medical conditions. These drugs will be identified on our **Drug List** and in Medicare.gov, along with the specific medical condition that they cover.

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

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

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

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

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

Section B2 How to find a drug on our Drug List

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

- Visit our plan's website found at the bottom of this page. The **Drug List** on our website is always the most current one.
- Call your service coordinator or Member Services to find out if a drug is on our **Drug List** or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at our plan's website to search for drugs on the **Drug List** to get an estimate of what you'll pay and if there are alternative drugs on the **Drug List** that could treat the same condition. You can also call your service coordinator or Member Services.

Section B3 Drugs not on our Drug List

We don't cover all drugs.

- Some drugs aren't on our **Drug List** because the law doesn't allow us to cover those drugs.
- In other cases, we decided not to include a drug on our **Drug List**.
- In some cases, you may be able to get a drug that isn't on our **Drug List**. For more information refer to **Chapter 9**.

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

Here are three general rules for excluded drugs:

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

Also, by law, Medicare or STAR+PLUS can't cover the types of drugs listed below.

- 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 the treatment of anorexia, weight loss or weight gain
- Outpatient drugs made by a company that says you must have tests or services done only by them

Section B4 Drug List cost-sharing tiers

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

Tier 1 is the lowest tier, includes generic drugs, and has a $0 cost share, Tier 2 includes generic drugs, Tier 3 includes preferred brand name drugs, and Tier 4 includes non-preferred drugs. The highest is Tier 5 and includes specialty drugs.

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

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

Section C Limits on some drugs

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

What is a compounded drug?

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

Does my Part D plan cover compounded drugs?

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

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

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

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

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

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

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

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

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

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

   Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. If there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you, respectively, the generic or interchangeable biosimilar version.

- We usually don't pay for the brand name drug or original biological product when there's an available generic version.
- However, if your provider told us the medical reason that the generic drug, interchangeable biosimilar, or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.
- Your copay may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.

2. **Getting plan approval in advance**

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

3. **Trying a different drug first**

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

   If Drug A doesn't work for you, then we cover Drug B. This is called step therapy. Call Member Services at the number at the bottom of the page or on our website found at the bottom of this page for more information about step therapy.

4. **Quantity limits**

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

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

Section D Reasons your drug might not be covered

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

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

- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.
- The drug is covered, but in a cost-sharing tier that makes your cost more expensive than you think it should be.

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

Section D1 Getting a temporary supply

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

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

1. The drug you've been taking:
   - is no longer on our **Drug List or**
   - was never on our **Drug List or**
   - is now limited in some way.
2. You must be in one of these situations:
   - You were in our plan last year.
     - We cover a temporary supply of your drug during the first 90 days of the calendar year.
     - This temporary supply is for up to 30 days.

     If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
   - You're new to our plan.
     - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
     - This temporary supply is for up to 31 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 31 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.

- You've been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
  - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - For current members with level of care changes: There may be unplanned transitions such as hospital discharges or level of care changes that happen while you are a member in our plan. If you are prescribed a drug that is not on our **Drug List** or your ability to get your drugs is limited, you must use the plan's exception process. You may ask for a one-time emergency supply of up at least 31 days to allow you time to discuss this with your doctor or to ask for a **Drug List** exception.

Section D2 Asking for a temporary supply

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

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

- Change to another drug.

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

OR

- Ask for an exception.

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

Section D3 Asking for an exception

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

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

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

If you need help asking for an exception, contact Member Services or your service coordinator.

Section E Coverage changes for your drugs

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

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Move a drug to a higher or lower cost-sharing tier.
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

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

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

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

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

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

- Check our current **Drug List** online at the site shown at the bottom of the page **or**
- Call Member Services at the number at the bottom of the page to check our current **Drug List**.

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

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

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

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

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

Some changes to the **Drug List** may include:

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

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

  When these changes happen, we'll:

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

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

  - If you should switch to the generic or interchangeable biosimilar or if there's a similar drug on the **Drug List** you can take instead or
  - Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9**.

Removing unsafe drugs and other drugs that are taken off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our **Drug List**. If you're taking the drug, we'll send you a notice after we make the change. If you are notified that a drug you are taking has been taken off the market, you should talk to your doctor or other prescriber.

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

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

When these changes happen, we:

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

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

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

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

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

For example, if we remove a drug you're taking increase what you pay for the drug, or limit its use, then the change doesn't affect your use of the drug or what you pay for the drug for the rest of the year.

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

We won't tell you above these types of changes directly during the current year. You'll need to check the **Drug List** for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan year.

Section F Drug coverage in special cases

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

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

To learn more about drug coverage and what you pay, refer to **Chapter 6** of this **Member Handbook**.

Section F2 In a long-term care facility

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

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

Section F3 In a Medicare-certified hospice program

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

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

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

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

Section G Programs on drug safety and managing drugs

Section G1 Programs to help you use drugs safely

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

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

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

Section G2 Programs to help you manage your drugs

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

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

Then, they'll give you:

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

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

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

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

If you have questions about these programs, contact Member Services or your service coordinator.

Section G3 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 prescriber to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescriber, if we decide your use of

prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may include:

- Requiring you to get all prescriptions for opioid or benzodiazepine medications from 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 provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter that confirms the limitations.

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

The DMP may not apply to you if you:

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

Chapter 6

What you pay for your Medicare and STAR+PLUS drugs

Chapter 6

What you pay for your Medicare and STAR+PLUS drugs

Introduction

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

- Medicare Part D drugs, **and**
- Drugs and items covered under Medicaid, **and**
- Drugs and items covered by our plan as additional benefits.

Because you're eligible for STAR+PLUS, you get Extra Help from Medicare to help pay for your Medicare Part D drugs. We have sent you a separate insert, called the "Member Handbook 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 Member Services and ask for the "LIS Rider."

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

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

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

- Our **List of Covered Drugs**.
  - We call this the **Drug List**. It tells you:
    - Which drugs we pay for
    - Which of the five tiers each drug is in
    - If there are any limits on the drugs
  - If you need a copy of our **Drug List**, call Member Services. You can also find the most current copy of our **Drug List** on our website found at the bottom of this page.
- **Chapter 5** of this **Member Handbook**.
  - It tells how to get your outpatient drugs through our plan.
  - It includes rules you need to follow. It also tells which types of drugs our plan doesn't cover.

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

– When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is an estimate of the out-of-pocket costs you're expected to pay. You can call your service coordinator or Member Services for more information.

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

Table of Contents

Section A The Explanation of Benefits (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

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

When you get drugs through our plan, we send you a summary called the **Explanation of Benefits**. We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. The EOB includes:

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

We offer coverage of drugs not covered under Medicare.

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

Section B How to keep track of your drug costs

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

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

1. **Use your UnitedHealthcare UCard.**

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

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

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

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

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

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

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

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

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

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

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

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call Member Services. You can also find answers to many questions on our website found at the bottom of this page.

What about possible fraud?

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

- Call Member Services or your Care Coordinator.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free.
- You can also call Texas Health and Human Services Office of the Inspector General to submit a complaint at 1-800-447-8477.

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

Section C Drug Payment Stages for Medicare Part D drugs

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

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

Section C1 Our plan has five cost sharing tiers

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

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

Tier 2 – Generic – Many generic drugs.

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

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

Note: 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.

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.

Tier 5 drugs is the next tier with the highest copay. They're specialty drugs. The average expected copay is expected to be $392.

Section C2 Your pharmacy choices

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

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

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

Section C3 Getting a long-term supply of a drug

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

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

Section C4 What you pay

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

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

For Members that Qualify for "Extra Help":

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

- $0
- $1.60

- $5.10

For all other drugs

- $0
- $4.90
- $12.65

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

	A network pharmacy A one-month or up to a 30-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this **Member Handbook** for details.
Cost-sharing Tier 1 (Preferred Generic)	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Cost-sharing Tier 2 (Generic)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-sharing Tier 3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-sharing Tier 4 (Non-Preferred)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance

	A network pharmacy A one-month or up to a 30-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this **Member Handbook** for details.
Cost-sharing Tier 5 (Specialty)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance

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

Section D Stage 1: The Initial Coverage Stage

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

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

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

Tier 2 – Generic – Many generic drugs.

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

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

Note: 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.

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.

Section D1 Your pharmacy choices

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

- A network retail pharmacy **or**
- A network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing.
- An out-of-network pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this **Member Handbook** to find out when we do that.
- Our plan's mail-order pharmacy.

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

Section D2 Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is a 100-day supply. It costs you the same as a one-month supply.

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

Section D3 What you pay

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

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

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 Texas Medicaid Health and Human Services Commission (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 share of the cost when you get a one-month or long-term supply of a covered drug from:

	A network pharmacy A one-month or up to a 30-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this **Member Handbook** for details.
Cost-sharing Tier 1 (Preferred Generic)	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Cost-sharing Tier 2 (Generic)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-sharing Tier 3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance

	A network pharmacy A one-month or up to a 30-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this **Member Handbook** for details.
Cost-sharing Tier 4 (Non-Preferred)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Cost-sharing Tier 5 (Specialty)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance

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

Section D4 End of the Initial Coverage Stage

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

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

Section E Stage 2: The Catastrophic Coverage Stage

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

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

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

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

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

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $6. This means that the amount you pay for your drug is $.20 per day. If you get a 7 days' supply of the drug, your payment is $.20 per day multiplied by 7 days, for a total payment of $1.40.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
  - Better plan when to refill your drugs,
  - Coordinate refills with other drugs you take, **and**
  - Take fewer trips to the pharmacy.

Section G What you pay for Part D vaccines

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

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

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

Section G1 What you need to know before you get a vaccine

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

- We can tell you about how our plan covers your vaccine and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider works with us to ensure that you have no upfront costs for a Medicare Part D vaccine.

Section G2 What you pay for a vaccine covered by Medicare Part D

What you pay for a vaccine depends on the type of vaccine (what you're being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of this **Member Handbook**.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's **Drug List**. You may have to pay a copay for Medicare Part D vaccines. If the vaccine is recommended for adults by an organization called the **Advisory Committee on Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccine.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
    - For most adult Part D vaccines, you'll pay nothing.
    - For other Part D vaccines, you may pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
    - You may pay a copay to the doctor for the vaccine.
    - Our plan pays for the cost of giving you the shot.
    - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay nothing for the vaccine.
3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
    - For most adult Part D vaccines, you'll pay nothing for the vaccine itself.
    - For other Part D vaccines, you pay a copay for the vaccine.
    - Our plan pays for the cost of giving you the shot.

Chapter 7

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

Chapter 7

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

Introduction

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

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Section A Asking us to pay for your services or drugs

Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We don't allow our providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for the full cost of health care or drugs, don't pay the bill and send the bill to us. To send us a bill, refer to **Chapter 2**.

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid more than your share of the cost, it's your right to be paid back.
  - If you paid for services covered by Medicare, we'll pay you back.
  - If you paid for services covered by STAR+PLUS, we can't pay you back, but the provider will. Member Services or your service coordinator can help you contact the provider's office. Refer to the bottom of the page for the Member Services phone number.
- If we don't cover the services or drugs, we'll tell you.

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

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

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

   Ask the provider to bill us.

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

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

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

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

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

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

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

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

   - In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
   - Refer to **Chapter 5** of this **Member Handbook** to learn more about out-of-network pharmacies.

- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. **When you pay the full Medicare Part D prescription cost because you don't have your UnitedHealthcare UCard with you**

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

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

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

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

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

   Important: If you are admitted to a hospital following a medical emergency while traveling outside the United States, call Member Services 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 Member Services 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 **Member Handbook**, 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 **Member Handbook**.
- You must request reimbursement from the Health Plan within 12 months from the date services are received. You must provide the following documentation with your submission:
  1. An itemized bill from the facility including the hospital's name, your's name, dates of stay, a list of charges, a brief description of each charge, and a total.
  2. A receipt/proof of payment showing that the amount on the bill was paid. Acceptable proofs of payment are credit card receipt, canceled check or bank statement. For cash payments, a provider's itemized invoice showing cash payment was made and detailing any remaining balance is acceptable.
  3. A copy of the medical record or documentation describing the medical situation and treatment course.

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

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

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

Section B Sending us a request for payment

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

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

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

Mail your request for payment together with any bills or receipts to 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 5290
Kingston, NY 12402-5290

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 C Coverage decisions

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

- We'll let you know if we need more information from you.

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

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

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

Section D Appeals

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

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

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

Chapter 8

Your rights and responsibilities

Chapter 8

Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

Table of Contents

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

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call your service coordinator or Member Services. Our plan has free interpreter services available to answer questions in different languages.
- We have written materials available in Spanish. We can provide information in other languages if you ask. We can also give you information in braille or large print. You can call Member Services and ask us to make a note in our system that you would like materials in Spanish, large print, braille, or audio now and in the future.
- To get materials in one of these alternative formats, please call Member Services or write to

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

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

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The Texas Civil Rights Office at 1-888-388-6332.
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

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

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this **Member Handbook**.
  - Call your service coordinator or Member Services or go to the **Provider and Pharmacy Directory** to learn more about network providers and which doctors are accepting new patients.

- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that isn't your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that's urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of this **Member Handbook**.

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

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

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

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

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

Section C1 How we protect your PHI

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

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

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

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws.

Section C2 Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. We may charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.

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

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

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

Effective January 1, 2025

By law, we must protect the privacy of your health information ("HI"). We must send you this notice.

It tells you:

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

By law, we must follow the terms of 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 UnitedHealthcare 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 UnitedHealthcare UCard**. Or you may contact the UnitedHealth Group Call Center at **1-866-944-4983**, or TTY/RTT **711**.
- **To Submit a Written Request.** Mail to:

  UnitedHealthcare Privacy Office
  MN017-E300
  P.O. 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.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE SAYS HOW YOUR FINANCIAL INFORMATION MAY BE USED AND SHARED. REVIEW IT CAREFULLY.

Effective January 1, 2025

We 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 health plan ID card or contact the UnitedHealth Group Customer Call Center at **1-866-944-4983**, or TTY/RTT **711**.

For purposes of this Financial Information Privacy Notice, "we" or "us" refers to health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc. Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Health Care Solutions, Inc.; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators

of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. For a current list of health plans subject to this notice go to https://www.uhc.com/privacy/entities-fn-v2.

Section D Our responsibility to give you information

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

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. We have printed materials in Spanish. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of this **Member Handbook**) and drugs (refer to **Chapters 5 and 6** of this **Member Handbook**) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this **Member Handbook**), including asking us to:
  - put in writing why something isn't covered
  - change a decision we made
  - pay for a bill you got

Section E Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services.

They also can't balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this **Member Handbook**.

Section F Your right to leave our plan

No one can make you stay in our plan if you don't want to.

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

Section G Your right to make decisions about your health care

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

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

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

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we'll not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.

- Ask us to cover a service or drug that we denied or usually don't cover. This is called a coverage decision. **Chapter 9** of this **Member Handbook** tells how to ask us for a coverage decision.

Section G2 Your right to say what you want to happen if you can't make health care decisions for yourself

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

- Fill out a written form **giving someone the right to make health care decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you **don't** want.

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

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

- **Get the form.** You can get the form from your doctor, a lawyer, a social worker, or some office supply stores. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form. Organizations that give people information about Medicare or Texas Medicaid, like the Health Information Counseling & Advocacy Program of Texas (HICAP), may also have advance directive forms.
- **Fill out the form and sign it.** The form is a legal document. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** Give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.
- If you're being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Member Services for more information.

Section G3 What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Texas Health and Human Services Commission Complaint and Incident Intake.

To report complaints, call 800-458-9858 Monday through Friday from 7 a.m.-7 p.m., email hfc.complaints@hhs.texas.gov, or visit the Texas Health and Human Services Commission Complaint and Incident Intake website (www.hhs.texas.gov/services/your-rights/complaint-incident-intake).

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

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

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

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

If you think we treated you unfairly — and it **isn't** about discrimination for reasons listed in **Chapter 11** of this **Member Handbook** — or you want more information about your rights, you can call:

- Member Services.
- The Health Information Counseling & Advocacy Program of Texas (HICAP) program at 800-252-9240. For more details about HICAP, refer to **Chapter 2**.
- The Texas Health and Human Services Office of the Ombudsman at 866-566-8989. For more details about this program, refer to **Chapter 2** of this **Member Handbook**.

Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf).

Section I Your responsibilities as a plan member

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

- **Read this Member Handbook** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of this **Member Handbook**. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of this **Member Handbook**.
- **Tell us about any other health or drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you're a member of our plan. Show your UnitedHealthcare UCard when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most of our members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.
  - For some of your long-term services and supports or drugs covered by our plan, you must pay your share of the cost when you get the service or drug. This will be a copayment. **Chapter 4** tells what you must pay for your long-term services and supports. **Chapter 6** tells what you must pay for your drugs.
  - **If you get any services or drugs that aren't covered by our plan, you must pay the full cost. (Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)

- **Tell us if you move.** If you plan to move, tell us right away. Call your service coordinator or Member Services.
  - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this **Member Handbook** tells about our service area.
  - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and STAR+PLUS your new address when you move. Refer to **Chapter 2** of this **Member Handbook** for phone numbers for Medicare and STAR+PLUS.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
  - **If you move, tell Social Security (or the Railroad Retirement Board).**
- **Call your service coordinator or Member Services for help if you have questions or concerns.**

Chapter 9

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

Chapter 9

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

Introduction

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

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

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

If you're facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your Plan of Care. **If you're having a problem with your care or Long-Term Services and Supports, you can call the HHSC Ombudsman's Office at 1-866-566-8989 for help.** This chapter explains the options you have for different problems and complaints, but you can always call the HHSC Ombudsman's Office to help guide you through your problem.

For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** for more information on ombudsman programs.

Table of Contents

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

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

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

Section A1 About the legal terms

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

For example, we say:

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

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

Section B Where to get help

Section B1 For more information and help

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

Help from the Health Information Counseling & Advocacy Program (HICAP).

You can also get help from HICAP. HICAP counselors can answer your questions and help you understand what to do about your problem. HICAP isn't connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. The HICAP phone number is 1-800-252-3439.

Help and information from Medicare

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

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from STAR+PLUS

If you need help with STAR+PLUS Medicaid services, contact:

Texas Medicaid Client Hotline

- Call 1-800-252-8263. TTY users call 7-1-1 or Relay Texas
- Visit HHSC website at www.hhs.texas.gov

Quality Improvement Organization (QIO), for Medicare appeal reviews:

- Call Acentra Health, Texas' Beneficiary and Family Centered Care–Quality Improvement Organization (BFCC-QIO): 1-888-315-0636
- Visit Acentra Health website at www.acentra.com

Texas HHS Office of the Ombudsman, for help with complaints or resolving problems

- Call 1-866-566-8989, TTY users call 711 or Relay Texas
- Visit HHS Office of the Ombudsman website at www.hhs.texas.gov/services/your-rights/hhs-office-ombudsman

Section C Understanding Medicare and STAR+PLUS complaints and appeals in our plan

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

Sometimes Medicare and STAR+PLUS processes can't be combined. In those situations, you use one process for a Medicare benefit and another process for a STAR+PLUS benefit. **Section F4** explains these situations.

Section D Problems with your benefits

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

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.	**No.** My problem isn't about benefits or coverage.
Refer to **Section E:** "Coverage decisions and appeals".	Refer to **Section K:** "How to make a complaint".

Section E Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple we generally refer to medical items, services, and Part B drugs as medical care.

Section E1 Coverage decisions

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

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

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or STAR+PLUS. If you disagree with this coverage decision, you can make an appeal.

Section E2 Appeals

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

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

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

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

Section E3 Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- **The Health Information Counseling & Advocacy Program (HICAP)**. The HICAP phone number is 1-800-252-3439.
- **The Texas Health and Human Services (HHS) Ombudsman's Office.** The HHS Ombudsman's Office helps people enrolled in STAR+PLUS with service or billing problems. The phone number is 1-866-566-8989.
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.

- **A lawyer.** You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

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

Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. **You must give us a copy of the signed form.**

Section E4 Which section of this chapter can help you

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

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

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page.

Section F Medical care

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

This section is about your benefits for medical care that's described in **Chapter 4** of this **Member Handbook** in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

Section F1 Using this section

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

1. You think we cover medical care you need but aren't getting.

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

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

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

3. You got medical care that you think we cover, but we won't pay.

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

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

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

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

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

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

Section F2 Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

Calling: **1-866-944-4983**
Calls to this number are free.
Hours of Operation: 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept

TTY: **711**
Calls to this number are free.

If you have questions, please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

Faxing: **1-888-950-1169**.

Writing: UnitedHealthcare Customer Service Department (Organization Determinations)
P.O. Box 30769
Salt Lake City UT 84130-0769

Website: **myUHC.com/CommunityPlan**

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer within:

- **7 calendar days** after we get your **request for a medical service or item that's subject to our prior authorization rules.**
- **14 calendar days** after we get your request **for all other medical services or items.**
- **72 hours** after we get your request **for a Medicare Part B drug.**

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we'll tell you in writing. **We can't take extra days if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days, you can make a "fast complaint" **about** our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.

Fast coverage decision

The legal term for fast coverage decision is **expedited determination**.

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we'll give you an answer within:

- **72 hours** after we get your request **for a medical service or item**.
- **24 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we'll tell you in writing. **We can't take extra time if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We'll call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You're asking for coverage for medical items and/or services that you **didn't get**. You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

Section F3 Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at **1-866-944-4983** (TTY **711**).

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

Ask for a standard appeal or a fast appeal in writing or by calling us at **1-866-944-4983** (TTY **711**).

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website found at the bottom of this page.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

The legal term for "fast appeal" is "**expedited reconsideration**."

- If you appeal a decision we made about coverage for care, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

If we tell you we're stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
  - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
  - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Texas a Fair Hearing is called Level 2 Appeal.
- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.

- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If you think we **shouldn't** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.
- If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about a STAR+PLUS service or item, you can ask for a Level 2 Appeal (known as a Fair Hearing) with the Texas Health and Human Services Commission (HHSC) Appeals Division. The letter will tell you how to do this. Information is also below.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights**:

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a STAR+PLUS service or item, the letter tells you how to file a Level 2 Appeal yourself.

Section F4 Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, STAR+PLUS or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that STAR+PLUS usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and STAR+PLUS** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only STAR+PLUS, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the Independent Review Organization (IRO) is the **Independent Review Entity**, sometimes called the **IRE**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO take extra time to make a decision if your request is for a Medicare Part B drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service,** we must:
  - Authorize the medical care coverage **within 72 hours, or**
  - Provide the service **within 14 calendar days** after we get the IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests**, or
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says No to part or all of your appeal,** it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that's covered by both Medicare and STAR+PLUS

A Level 2 Appeal for services that STAR+PLUS usually covers is a State Fair Hearing with the Texas HHSC Fair Hearings Department. You must ask for a State Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a State Fair Hearing.

The State Fair Hearings Officer gives you their decision in writing and explain the reasons.

- If the State Fair Hearings Officer says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the State Fair Hearings Officer says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for the requested service or item. This is called "upholding the decision"

If the State Fair Hearings Officer's decision is **No** for all or part of your request, you can request an Administrative Review within 30 days from the date of the decision. The Fair Hearings Officer's decision describes how to request an Administrative Review. An Administrative Review is completed by an Administrative Law Judge from the Texas HHSC Appeals Division.

Refer to **Section J** for more information about your appeal rights after Level 2 Appeal.

Section F5 Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for the service, item, and/or drug.

If you get a bill that's more than your copay for covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of this **Member Handbook**. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you're asking for a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we'll send you the payment for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we'll send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.

- If the service or item isn't covered or you didn't follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and STAR+PLUS usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

Section G Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that STAR+PLUS may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this **Member Handbook** for more information about a medically accepted indication.

Section G1 Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that isn't on our plan's **Drug List** or

– set aside a restriction on our coverage for a drug (such as limits on the amount you can get)

- You ask us if a drug is covered for you (such as when your drug is on our plan's **Drug List** but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a "**coverage determination**."

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our **Drug List** or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our **Drug List**, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you are asking us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4**.	Refer to **Section G4**.	Refer to **Section G4.**	Refer to **Section G5**.

Section G2 Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our **Drug List** or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception".**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that isn't on our Drug List**
    - If we agree to make an exception and cover a drug that isn't on our **Drug List**, you pay the copay that applies drug tiers 2–5.

- You can't get an exception to the required copay amount for the drug.

2. **Removing a restriction for a covered drug**
   - Extra rules or restrictions apply to certain drugs on our **Drug List** (refer to **Chapter 5** of this **Member Handbook** for more information).
   - Extra rules and restrictions for certain drugs include:
     – Being required to use the generic version of a drug instead of the brand name drug.
     – Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
     – Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
   - If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our **Drug List** is in one of five cost-sharing tiers (tiers 1–5). In general, the lower the cost-sharing tier number, the less your required copay amount is. Tier 1 has a $0 cost share.
   - Our **Drug List** often includes more than one drug for treating a specific condition. These are called "alternative" drugs.
   - If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
     – If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.
     – If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
     – If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.
   - You can't ask us to change the cost-sharing tier for any drug in tier 5 (specialty).
   - 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 usually pay the lowest amount.

Section G3 Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

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

Our **Drug List** often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request. If you ask us for a tiering exception, we generally **don't** approve your exception request unless all 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 say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

Section G4 Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling **1-866-944-4983** (TTY **711**), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this **Member Handbook**.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

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

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Section G5 Making a Level 1 Appeal

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

- Start your **standard** or **fast appeal** by calling **1-866-944-4983** (TTY **711**), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

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

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Section G6 Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

The formal name for the "Independent Review Organization" (IRO) is the "**Independent Review Entity**", sometimes called the "**IRE**".

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file.**

- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section H Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this **Member Handbook**.

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

Section H1 Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1 800-MEDICARE (1-800-633-4227). TTY users should call 1 877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing **doesn't** mean you agree to a discharge date your doctor or the hospital staff may have told you.

- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1 800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section H2 Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In Texas, the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) is Acentra Health. Call them at 1-888-315-0636. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave,** you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal,** and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Health Information Counseling and Advocacy Program (HICAP) with Texas Department of Aging and Disability at 1-800-252-9240.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

The legal term for "**fast review**" is "**immediate review**" or "**expedited review**."

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

Section H3 Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-315-0636.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for our share of hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section I Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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

Section I1 Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care.

This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing **doesn't** mean you agree with our decision.

Section I2 Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the Heath Information, Counseling, and Advocacy Program (HICAP) at 1-800-252-9240.
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of this **Member Handbook** for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

The legal term for the written notice is **"Notice of Medicare Non-Coverage"**. To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is "**Detailed Explanation of Non-Coverage**".

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying our share of the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

Section I3 Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-315-0636.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section J Taking your appeal beyond Level 2

Section J1 Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

Section J2 Additional STAR+PLUS appeals

You also have more appeal rights if your appeal is about services or items that might be covered by STAR+PLUS. If you have questions about your additional appeal rights, you can call the HHSC Ombudsman's Office at 1-866-566-8989.

If you don't agree with a decision given by the Fair Hearings officer, you may request an Administrative Review within 30 days of the date on the decision.

The letter you get from the HHSC Appeals Division will tell you what to do if you wish to continue the appeals process.

Section J3 Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be right for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

Section K How to make a complaint

Section K1 What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone didn't respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you're being pushed out of our plan.
Accessibility and language assistance	• You can't physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider doesn't give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office isn't clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call HHSC Ombudsman's Office at 1-866-566-8989.

? **If you have questions,** please call UHC Dual Complete TX-Y1 (HMO-POS D-SNP) at Toll-free **1-866-944-4983**, TTY **711**, 8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept. The call is free. **For more information, visit myUHC.com/CommunityPlan**.

The legal term for a "complaint" is a "**grievance**."

The legal term for "making a complaint" is "**filing a grievance**."

Section K2 Internal complaints

To make an internal complaint, call Member Services at **1-866-944-4983** (TTY 711). You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there's anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.

The legal term for "fast complaint" is "**expedited grievance**."

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

Section K3 External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/my/medicare-complaint. You don't need to file a complaint with us before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. The call is free.

STAR+PLUS

Once you have gone through the plan's complaint process, you can submit a complaint to the Texas Health and Human Services Commission (HHSC) by calling toll-free 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission

Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, TX 78711-3247

If you can get on the Internet, you can submit your complaint at: www.hhs.texas.gov/services/your-rights/hhs-office-ombudsman/ombudsman-complaint-process

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at: **1-888-388-6332**.

You may also have rights under the Americans with Disability Act (ADA) and under certain state laws. You can contact the Civil Rights Office of the Texas Health and Human Services Commission by e-mail at HHSCivilRightsOffice@hhsc.state.tx.us or by phone at 1-888-388-6332.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.

- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of this **Member Handbook**.

In Texas the BFCC-QIO is called Acentra. The phone number for Acentra is 1-888-315-0636.

Chapter 10

Ending your membership in our plan

Chapter 10

Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and STAR+PLUS programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

Table of Contents

Section A When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have STAR+PLUS you have some choices to end your membership with our plan any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for STAR+PLUS or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medicaid services in **Section C2**.

You can get more information about how you can end your membership by calling:

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP), the Health Information Counseling & Advocacy Program of Texas (HICAP) at 1-800-252-9240, Monday-Friday, 8:00 a.m. to 5:00 p.m. CST.

Section B How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in **Section D**.

Section C How to get Medicare and STAR+PLUS services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

Section C1 Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	Here is what to do:
Another plan that provides your Medicare and most or all of your STAR+PLUS benefits and services in one plan. If you choose another Medicare plan that also provides your STAR+PLUS benefits, your STAR+PLUS plan will also change to the same plan that provides your Medicare benefits. You don't need to take any action for this to occur. **OR** **You can enroll in the Program of All-Inclusive Care for the Elderly (PACE). PACE is available in Potter, Randall, El Paso, and Lubbock Counties. If you choose to enroll in PACE, the benefits include, but aren't limited to, all Medicaid and Medicare covered services including prescription drugs. You must receive all needed health care services, including primary care and specialist physician services (other than emergency services), from the PACE organization or an entity authorized by the PACE organization.** **To get more information about PACE, call Texas PACE Program at 1-512-487-3450.**	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For information regarding PACE provider enrollment and policy, you can contact the Texas Health and Human Services Commission (HHSC) at 512-487-3450. This number connects you with the Community Services Policy Unit, which oversees PACE operations in Texas. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday–Friday, 8:00 a.m. to 5:00 p.m. CST. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/about/contact-us/where-can-i-find-services. **OR** Enroll in a plan that provides your Medicare and most or all of your STAR+PLUS benefits and services in one plan. If you enroll in a new plan, you'll automatically be disenrolled from our plan when your new plan's coverage begins.

2. You can change to: **Original Medicare with a separate Medicare drug plan.** **If you choose to move to Original Medicare, your STAR+PLUS plan will remain the same. You don't have to take any action for this to occur.**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday–Friday, 8:00 a.m. to 5:00 p.m. CST. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/about/contact-us/where-can-i-find-services. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan for your Medicare benefits when your Original Medicare coverage begins, but you'll continue to be enrolled in our STAR+PLUS plan for your Medicaid benefits. You don't have to take any action for this to occur.

3. You can change to: **Original Medicare without a separate Medicare drug plan.** **If you choose to move to Original Medicare, your STAR+PLUS plan will remain the same. You don't have to take any action for this to occur.** **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday-Friday, 8:00 a.m. to 5:00 p.m. CST. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/about/contact-us/where-can-i-find-services.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday–Friday, 8:00 a.m. to 5:00 p.m. CST. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/about/contact-us/where-can-i-find-services. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins, but you'll continue to be enrolled in our STAR+PLUS plan for your Medicaid benefits. You don't have to take any action for this to occur.

4. You can change to:	Here is what to do:
Any Medicare health plan during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. If you choose another Medicare plan that also provides your STAR+PLUS benefits during certain times of the year, your STAR+PLUS plan will also change to the same plan that provides your Medicare benefits. You don't need to take any action for this to occur. If you choose to enroll in any other Medicare health plan, such as a Medicare Advantage Plan (MAP) or Original Medicare, during certain times of the year, then your STAR+PLUS plan will remain the same. In this situation, if you want to change your STAR+PLUS plan, you can change at any time by contacting the state Enrollment Broker 1-877-782-6440 or TTY: 711, 8:00 a.m. to 6:00 p.m. CST, Monday-Friday.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For information regarding PACE provider enrollment and policy, you can contact the Texas Health and Human Services Commission (HHSC) at 512-487-3450. This number connects you with the Community Services Policy Unit which oversees PACE operations in Texas. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-252-9240, Monday-Friday, 8:00 a.m. to 5:00 p.m. CST. In Texas, the SHIP is called the Health Information Counseling & Advocacy Program of Texas (HICAP). For more information or to find a Health Information Counseling & Advocacy Program of Texas (HICAP) office in your area, please visit www.hhs.texas.gov/about/contact-us/where-can-i-find-services. **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. If you choose another Medicare plan that also provides your STAR+PLUS benefits, you don't need to take any action for your STAR+PLUS plan to automatically align with your new Medicare plan. If you choose to enroll in any other Medicare health plan, such as a Medicare Advantage Plan (MAP) or Original Medicare, then your STAR+PLUS plan will remain the same. If you want to change your STAR+PLUS plan, you can change at any time by contacting the state Enrollment Broker 1-877-782-6440 or TTY: 711, 8:00 a.m. to 6:00 p.m. CST, Monday–Friday.

Section C2 Your STAR+PLUS services

For questions about how to get your STAR+PLUS services after you leave our plan, call the State enrollment broker at 1-877-782-6440 or TTY: 711, 8:00 a.m. to 6:00 p.m. CST, Monday-Friday. Ask how joining another plan or returning to Original Medicare affects how you get your STAR+PLUS coverage.

Section D Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your membership in UHC Dual Complete TX-Y1 (HMO-POS D-SNP) ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

Section E Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you're away from our service area for more than six months.
  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or aren't lawfully present in the United States.

- You must be a United States citizen or lawfully present in the United States to be a member of our plan.
- The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
- We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your UnitedHealthcare UCard to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

Section F Rules against asking you to leave our plan for any health-related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Section G Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this **Member Handbook** for information about how to make a complaint.

Section H How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

Chapter 11

Legal notices

Chapter 11

Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this **Member Handbook**.

Table of Contents

Section A Notice about laws

Many laws apply to this **Member Handbook**. These laws may affect your rights and responsibilities even if the laws aren't included or explained in this **Member Handbook**. The main laws that apply are federal laws about the Medicare and STAR+PLUS programs. Other federal and state laws may apply too.

Section B Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1 800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights at 1-888-388-6332.
- If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section C Notice about Medicare as a second payer and STAR+PLUS as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that STAR+PLUS is the payer of last resort.

Optum Financial®

Privacy notice

Rev. 08/2025

Facts	What does Optum Bank do with your personal information?
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Medicare Beneficiary Identifier or Member Identification Number and account balances • Payment history and transaction history • Purchase history and account transactions When you are no longer our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share members' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their members' personal information, the reasons Optum Bank chooses to share and whether you can limit this sharing.

Reasons we can share your personal information	Does Optum Bank share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – information about your transactions and experiences, which is not used by affiliates to market their products to you	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?	**Please call 1-866-234-8913 or visit us online at optumbank.com.**

What we do	
How does **Optum Bank** protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We also have additional safeguards to protect your information and we limit who can access it.
How does **Optum Bank** collect my personal information?	We collect your personal information, for example, when you: • Use your payment card or pay a bill • Update your contact information We also collect your personal information from others, such as affiliates or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only: • Sharing for affiliates' everyday business purposes – information about your creditworthiness • Affiliates from using your information to market to you • Sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. • Our affiliates include companies within UnitedHealth Group and those companies that share the Optum name; financial companies such as Optum Financial, Inc. and UnitedHealthcare Insurance Company; and nonfinancial companies such as UHG Print Services.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • Optum Bank does not share with nonaffiliates so they can market to you.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • Optum Bank does not engage in any joint marketing.

Chapter 12

Definitions of important words

Chapter 12

Definitions of important words

Introduction

This chapter includes key terms used throughout this **Member Handbook** with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this **Member Handbook** explains appeals, including how to make an appeal.

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.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Biological Product: A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (See also "Original Biological Product" and "Biosimilar").

Biosimilar: A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (Go to "Interchangeable Biosimilar").

Brand name drug: A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

Catastrophic coverage stage: The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the year.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of this **Member Handbook** explains how to contact CMS.

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

Coinsurance: An amount you may be required to pay, expressed as a percentage (for example 25%) 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.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance”.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Copay: A fixed amount you pay as your share of the cost each time you get certain services or drugs. For example, you might pay $2 or $5 for a service or a drug.

Cost-sharing: Amounts you have to pay when you get certain services or drugs. Cost-sharing includes copays.

Cost-sharing tier: A group of drugs with the same copay. Every drug on the **List of Covered Drugs** (also known as the **Drug List**) is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of this **Member Handbook** explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Daily cost-sharing rate: A rate that 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 copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply.

- Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7-day supply of the drug, your payment is less than $0.05 per day multiplied by 7 days, for a total payment less than $0.35.

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

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Drug tiers: Groups of drugs on our **Drug List**. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the **Drug List** is in one of 5 tiers.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you're a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

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

Exception: A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Excluded Services: Services that aren't covered by this health plan.

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

Generic drug: A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Services if you get any bills you don't understand. As a plan member, you only pay our plan's cost-sharing amounts when you get services we cover. We **don't** allow providers to bill you more than this amount.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.

Initial coverage stage: The stage before your total Medicare Part D drug expenses reach $2,100. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

Inpatient: A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (Drug List): A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The **Drug List** tells you if there are any rules you need to follow to get your drugs. The **Drug List** is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help"

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage: A Medicare program, also known as "Medicare Part C" or "MA", that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a "dually eligible individual".

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as "Medicare Advantage" or "MA", that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to **Chapter 5** of this **Member Handbook** for more information.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Handbook and Disclosure Information: This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this **Member Handbook** for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They're licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and don't charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers".

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman's services are free. You can find more information in **Chapters 2 and 9** of this **Member Handbook.**

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of this **Member Handbook** explains coverage decisions.

Original Biological Product: A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It's also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that hasn't agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out of network pharmacies unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. **Chapter 3** of this **Member Handbook** explains out-of-network providers or facilities.

Out-of-pocket costs: The cost- sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. Refer to the definition for "cost-sharing" above.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

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 use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.

- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this **Member Handbook** for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

- Our plan covers some network medical services only if your doctor or other network provider gets PA from us.
- Covered services that need our plan's PA are marked in **Chapter 4** of this **Member Handbook**.
- Our plan covers some drugs only if you get PA from us.
- Covered drugs that need our plan's PA are marked in the **List of Covered Drugs** and the rules are posted on our website.

Program of All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people aged 55 and over who need a higher level of care to live at home.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this **Member Handbook** for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this **Member Handbook**.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of this **Member Handbook** to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Service Coordination Team: A service coordination team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your service coordination team also helps you make a service plan.

Service coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Service Plan: A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Share of cost: The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

STAR+PLUS: This is the name of Texas' Medicaid program. STAR+PLUS is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

State Hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to obtain services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).

UHC Dual Complete TX-Y1 (HMO-POS D-SNP) Member Services:

myUHC.com/CommunityPlan

Call **1-866-944-4983**
Calls to this number are free.
8 a.m.–8 p.m.: 7 Days Oct–Mar; M–F Apr–Sept
Member Services 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

Fax **1-888-950-1169**

Write: **P.O. Box 30769**
Salt Lake City UT 84130-0769