Member Handbook 2024

UHC Dual Complete MN-Y002 (HMO D-SNP)

Toll-free **1-844-368-5888**, TTY **711**, or your preferred relay service
8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September

myuhc.com/communityplan

United Healthcare®
Community Plan

Y0066_EOC_H0845-001-000-2024 OMB Approval 0938-1444 (Expires: June 30, 2026)

January 1–December 31, 2024

Your Medicare and Medical Assistance Health, Long-Term Services and Supports, and Drug Coverage under UHC Dual Complete® (HMO 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, 2024. It explains health care services. Key terms and their definitions appear in alphabetical order in Chapter 12 of your **Member Handbook**.

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

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

ATTENTION: If you speak another language other than English, language assistance services, free of charge, are available to you. Call our plan's Member Services at the number at the bottom of this page. The call is free.

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

To make or change a standing request to get this document, now and in the future, in a language other than English or in an alternate format, call Member Services at the number at the bottom of this page.

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at **1-844-368-5888**, TTY **711**, or use your preferred relay service. Someone that speaks your language can help you. This is a free service.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

2024 Member Handbook Table of Contents

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

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Disclaimers

- We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.
- Benefits may change on January 1, 2025.
- The formulary, pharmacy network, and provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.
- Every year, Medicare evaluates plans based on a 5 Star rating system.
- Coverage under UHC Dual Complete® (HMO D-SNP) is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at **irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information on the individual shared responsibility requirement.
- UHC Dual Complete® (HMO D-SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in UHC Dual Complete® (HMO D-SNP) depends on contract renewal.
- We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact **medicare.gov** or **1-800-MEDICARE** to get information on all of your options.
- Benefits, features and/or devices vary by plan/area. Limitations, exclusions and/or network restrictions may apply.
- Network size varies by local market and exclusions may apply.
- The Renew Active® Program varies by plan/area and may not be available on all plans. Participation in the Renew Active program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership and other offerings. Fitness membership equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Certain services, discounts, classes, events, and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services are subject to your acceptance of their respective terms and policies.
- UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a provider.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- AARP® Staying Sharp® is the registered trademark of AARP. Staying Sharp, including all content and features, is offered for informational purposes and to educate users on brain health care and medical issues that may affect their daily lives. Staying Sharp is based on a holistic, lifestyle approach to brain health that encourages users to incorporate into their daily lives activities that are associated with general wellness. Nothing in the service should be considered, or used as a substitute for, medical advice, diagnosis, or treatment. Features including the Cognitive Assessment and Lifestyle Check-Ins,
- Additional Tests, exercises, and challenges assess performance at a particular moment in time on certain discrete cognitive tasks. Staying Sharp games are intended for entertainment and recreational purposes only. Various factors may affect performance, including sleep, tiredness, focus, and other social, environmental, or emotional factors.
- Performance is not indicative of cognitive health and not predictive of future performance or medical conditions.
- The AbleTo mobile application should not be used for urgent care needs. If you are experiencing a crisis or need emergency care, call 911 or go to the nearest emergency room. The Self Care information contained in the AbleTo mobile application is for educational purposes only; it is not intended to diagnose problems or provide treatment and should not be used on its own as a substitute for care from a provider. AbleTo Self Care is available to members ages 13+ at no additional cost as part of your benefit plan. Self Care is not available for all groups in District of Columbia, Maryland, New York, Pennsylvania, Virginia or West Virginia and is subject to change. Refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on your health plan ID card. Participation in the program is voluntary and subject to the Terms of Use contained in the mobile application. AbleTo is majority owned by OptumHealth Holdings, LLC, a UnitedHealthcare affiliate.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

United Healthcare Community Plan

CB5 (MCOs) (10-2021)

Civil Rights Notice

Discrimination is against the law. UnitedHealthcare Community Plan of Minnesota does not discriminate on the basis of any of the following:

- Race
- Color
- National origin
- Creed
- Religion
- Sexual orientation
- Public assistance status
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)
- Marital status
- Political beliefs
- Medical condition
- Health status
- Receipt of health care services
- Claims experience
- Medical history
- Genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UnitedHealthcare Community Plan of Minnesota. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
Toll Free: **1-844-368-5888**, TTY **711**
Email: **UHC_Civil_Rights@uhc.com**

Auxiliary Aids and Services: UnitedHealthcare Community Plan of Minnesota provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact Member Services at 1-844-368-5888.**

Language Assistance Services: UnitedHealthcare Community Plan of Minnesota provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact Member Services at 1-844-368-5888.**

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by UnitedHealthcare Community Plan of Minnesota. You may also contact any of the following agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Age
- Disability
- Sex
- Religion (in some cases)

Contact the **OCR** directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601

Customer Response Center: Toll-free: 800-368-1019
TDD Toll-free: 800-537-7697
Email: **ocrmail@hhs.gov**

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- Race
- Color
- National origin
- Religion
- Creed
- Sex
- Sexual orientation
- Marital status
- Public assistance status
- Disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104

Voice: 651-539-1100
Toll free: 800-657-3704
MN Relay: 711 or 800-627-3529
Fax: 651-296-9042
Email: **Info.MDHR@state.mn.us**

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- Race
- Color
- National origin
- Religion (in some cases)
- Age
- Disability (including physical or mental impairment)
- Sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
Voice: 651-431-3040 or use your preferred relay service

American Indian Health Statement

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

1-844-368-5888, TTY **711**

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအား အခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကို ခေါ်ဆိုပါ။*

កំណត់សម្គាល់៖ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះ ដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သး. နမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီနၤလၢ တၢ်ကကွဲးကျိုးထံဝဲဒဉ် လံာ်တီလံာ်မိတခါအံၤအဃိ ကိးလိတဲစိနိဉ်ဂ့ၢ် လၢထးအံၤန့ဉ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Chapter 1

Getting started as a member

Introduction

This chapter includes information about UHC Dual Complete® (HMO D-SNP), a health plan that covers all of your Medicare and Medical Assistance services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your **Member Handbook.**

Table of Contents

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section A Welcome to our plan

Our plan is a Medicare Advantage Special Needs Plan. A Special Needs Plan has a network made up of doctors, hospitals, pharmacies, providers of long-term services and supports (LTSS), and other providers. It also has care coordinators and care teams to help you manage all of your providers and services. They all work together to provide the care you need.

Our plan was approved by the State of Minnesota and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of Minnesota Senior Health Options (MSHO).

MSHO is a demonstration program jointly run by Minnesota and the federal government to provide better health care for people who have both Medicare and Medical Assistance. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medical Assistance health care services.

UHC Dual Complete® (HMO D-SNP) is run by a private company. Like all Medicare Advantage plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the State of Minnesota to coordinate your Medical Assistance benefits. We are pleased to be providing your Medicare health care coverage, including your prescription drug coverage.

Section B Information about Medicare and Medical Assistance

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 Medical Assistance

Medical Assistance is the name of Minnesota Medicaid program. Medical Assistance is run by the state and is paid for by the state and the federal government. Medical Assistance 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 Minnesota approved our plan. You can get Medicare and Medical Assistance services through our plan as long as:

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

Even if our plan stops operating in the future, your eligibility for Medicare and Medical Assistance services will not be affected.

Section C Advantages of our plan

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

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

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

Section D Our plan's service area

Our service area includes St. Louis county in Minnesota.

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

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

You cannot stay in our plan if you move outside of our service area. Refer to **Chapter 8** of your **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 are eligible for our plan as long as you:

- live in our service area (incarcerated individuals are not considered living in the service area even if they are physically located in it), **and**
- have 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 Medical Assistance, **and**
- are age 65 or over.

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

Call Member Services for more information.

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

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

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

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

We'll send you more information about this HRA.

Section G Your care team and care plan

Section G1 Care team

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

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call

us at the numbers at the bottom of the page for more information about your care coordinator and care team.

Section G2 Care plan

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

Your care plan includes:

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

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

Section H Your monthly costs for UHC Dual Complete® (HMO D-SNP)

Our plan has no premium.

Section I Your Member Handbook

Your **Member Handbook** is part of our contract with you. This means that we must follow the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to Chapter 9 of your **Member Handbook**, or call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

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** tour on our website **myuhc.com/communityplan**.

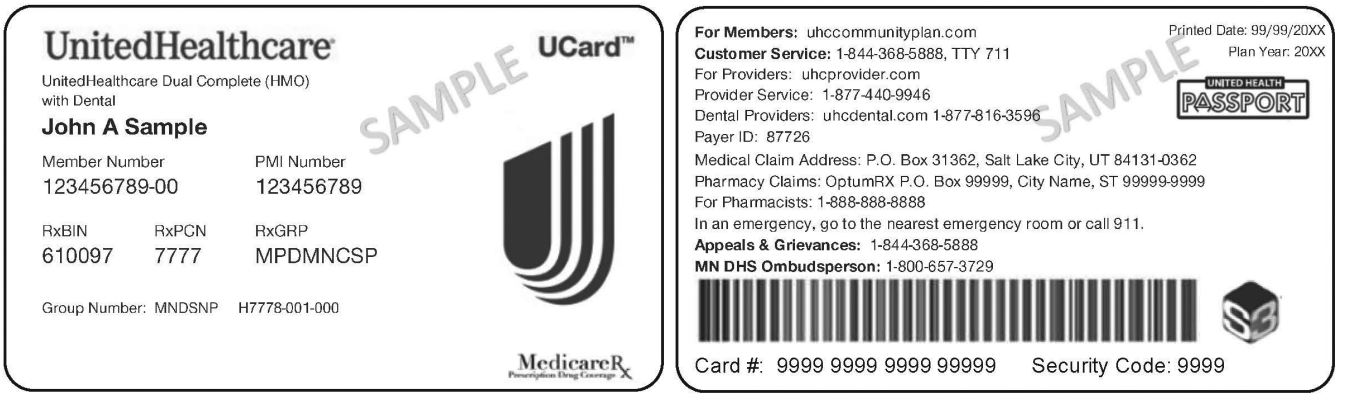
The contract is in effect for the months you are enrolled in our plan between January 1, 2024 and December 31, 2024.

Section J Other important information you will get from us

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

Section J1 Your Member ID Card

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



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

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Medical Assistance card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7 of your **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 a hard copy of the **Provider and Pharmacy Directory** will be mailed to you within three business days. You can also refer to the **Provider and Pharmacy Directory** at our web address at the bottom of this page.

Both Member Services and the website can give you the most up-to-date information about changes in our network pharmacies and providers.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Definition of network providers

- Our network providers include:
  - Doctors, nurses, and other health care professionals that you can use as 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 Medical Assistance.

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.

Section J3 List of Covered Drugs

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

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to Chapter 5 of your **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 prescription drug benefits, we will send you a summary to help you understand and keep track of payments for your Medicare Part D prescription drugs. This summary is called the **Explanation of Benefits** (EOB).

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

The EOB tells you the total amount you, or others on your behalf, have spent on your Medicare Part D prescription drugs and the total amount we have paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take. Chapter 6 of your **Member Handbook** gives more information about the EOB and how it can help you keep track of 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 Keeping your membership record up to date

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

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

Tell us right away about the following:

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

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

In addition, call your county worker to report these changes:

- Name or address changes
- Admission to a nursing home
- Addition or loss of a household member
- Lost or stolen Minnesota Health Care Program ID Card
- New insurance, providing the start and end dates.
- New job or change in income

Section K1 Privacy of personal health information (PHI)

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

Chapter 2

Important phone numbers and resources

Introduction

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

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? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section A Member Services

Method	Member services — Contact information
Call	**1-844-368-5888** The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September We have free interpreter services for people who do not speak English.
TTY	**711**, or your preferred relay service. The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September
Write	P.O. Box 30769 Salt Lake City, UT 84130-0769
Website	**myuhc.com/communityplan**

Method	Coverage Decisions for Part D prescription drugs — Contact information
Call	**1-844-368-5888** The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September We have free interpreter services for people who do not speak English. **Part D Expedited Phone Number** **1-855-409-7041**
TTY	**711**, or your preferred relay service. The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September
Fax	Fax-Standard **1-866-308-6294** Fax-Expedited **1-866-308-6296**
Write	UnitedHealthcare Part D Appeal and Grievance Department P.O. Box 6103, MS CA124-0197 Cypress, CA 90630-0023
Website	**myuhc.com/communityplan**

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Method	Appeals for Medical Care — Contact information
Call	**1-844-368-5888** The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September We have free interpreter services for people who do not speak English.
TTY	**711**, or your preferred relay service. The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September
Fax	Fax-Standard **1-866-373-1081** Fax-Expedited **1-888-517-7113**
Write	UnitedHealthcare Appeal and Grievance Department Attn: Complaint and Appeals Department P.O. Box 6103, MS CA124-0187 Cypress, CA 90630-0023
Website	**myuhc.com/communityplan**

Contact Member Services to get help with:

- Questions about the plan
- Questions about claims or billing
- Coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services, **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to Chapter 9 of your **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 your **Member Handbook** or contact Member Services.
- Complaints about your health care

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

  - 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 health plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).
  - You can call us and explain your complaint at **1-844-368-5888**.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at **medicare.gov/MedicareComplaintForm/home.aspx**. Or you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, to ask for help. TTY users should call **1-877-486-2048**.
  - To learn more about making a complaint about your health care, refer to Chapter 9 of your **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, Medical Assistance prescription drugs, and Medical Assistance over-the-counter drugs.
  - For more on coverage decisions about your prescription drugs, refer to Chapter 9 of your **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 prescription drugs, refer to Chapter 9 of your **Member Handbook**.
- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan right to Medicare. You can use an online form at **medicare.gov/MedicareComplaintForm/home.aspx**. Or you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, to ask for help. TTY users should call **1-877-486-2048**.

- For more on making a complaint about your prescription drugs, refer to Chapter 9 of your **Member Handbook**.

- Payment for health care or drugs you already paid for
  - We do not allow UHC Dual Complete® (HMO D-SNP) providers to bill you for services. We pay our providers directly, and we protect you from any charges. The exception is if you pay for Medicare Part D prescription drugs. If you paid for a service that you think we should have covered, contact Member Services at the phone number printed at the bottom of this page.
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to Chapter 7 of your **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 your **Member Handbook** for more on appeals.

Section B Your Care Coordinator

Method	Care Coordinator — Contact information
Call	**1-844-368-5888** The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September We have free interpreter services for people who do not speak English.
TTY	**711**, or your preferred relay service. The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September
Write	P.O. Box 30769 Salt Lake City, UT 84130-0769
Website	**myuhc.com/communityplan**

Contact your care 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 getting behavioral health services, transportation, and long-term services and supports (LTSS)
  - You must have a Long-Term Care Consultation (LTCC) done and be found to be eligible to get additional services or support. You can ask to have this assessment in your home, apartment, facility where you live, or another agreed-upon location.
  - Your care coordinator will meet with you and your family to talk about your care needs if you call to ask for a visit.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

– Your care coordinator will give you information about community services, help you find services to stay in your home or community, and help you find services to move out of a nursing home or other facility.
– Sometimes you can get help with your daily health care and living needs. You might be able to get these services if you need them:
  • Skilled nursing care
  • Physical therapy
  • Occupational therapy
  • Speech therapy
  • Medical social services
  • Home health care

Section C How to contact the Nurse Hotline

Speak to a registered nurse (RN) about your medical concerns and questions.

Nurse Hotline not for use in emergencies, for informational purposes only.

Method	Nurse Hotline — Contact information
Call	**1-877-440-9407** The call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	**711**, or your preferred relay service. The call is free. 24 hours a day, 7 days a week

Contact your the Nurse Hotline to get help with:

• Questions about your health or health care treatment options

Section D The Behavioral Health Crisis Line

Method	Behavioral Health Crisis Line — Contact information
Call	**1-844-368-5888** The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September We have free interpreter services for people who do not speak English.
TTY	**711**, or your preferred relay service. The call is free. 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September

Contact your the Behavioral Health Crisis Line to get help with:

- Questions about your health or health care treatment options
- Questions about substance use disorder services

Section E Senior LinkAge Line®

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Minnesota, the SHIP is called the Senior LinkAge Line®.

The Senior LinkAge Line® is not connected with any insurance company or health plan.

Method	Senior LinkAge Line® — Contact information
Call	**1-800-333-2433** The call is free.
TTY	Call the Minnesota Relay Service at **711** or use your preferred relay service. The call is free.
Write	Minnesota Board on Aging PO Box 64976 St. Paul, MN 55164-0976
Website	**seniorlinkageline.com**

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Contact Senior LinkAge® Line for help with:

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

Section F The Quality Improvement Organization (QIO)

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

Method	Livanta — Contact information
Call	**1-888-524-9900** Monday through Friday, 9:00 a.m.–5:00 p.m. Weekend and Holidays, 11:00 a.m.–3:00 p.m. 24-hour voicemail is available
TTY	**1-888-985-8775** This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
Write	10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
Website	**livantaqio.com**

Contact Livanta for help with:

- questions about your health care rights
- making a complaint the care you got if you:
  - have a problem with the quality of care,

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

– 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 G Medicare

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

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

Method	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	**medicare.gov** This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has documents you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you.

Section H Medical Assistance

Medicaid is a joint Federal and state government program. Medical Assistance helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call the Minnesota Department of Human Services.

Method	Medical Assistance — Contact information
Call	Minnesota Department of Human services **1-651-431-2670** (Twin Cities Metro area) Or **1-800-657-3739** (Outside the Twin Cities Metro area) The call is free.
TTY	**1-800-627-3529** (You need special telephone equipment to call this number.) Or **711** or use your preferred relay service (You do not need special telephone equipment to call this number.) These calls are free.
Write	Department of Human Services of Minnesota 444 Lafayette Road North St. Paul, MN 55155
Email	**DHS.info@state.mn.us**
Website	**mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp**

Section I Ombudsperson for Public Managed Health Care Programs

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

Method	Ombudsperson for Public Managed Health Care Programs — Contact information
Call	**1-651-431-2660** (Twin Cities Metro area) Or **1-800-657-3729** (Outside Twin Cities Metro area) The call is free.
TTY	**1-800-627-3529** (You need special telephone equipment to call this number.) Or **711** or use your preferred relay service (You do **not** need special telephone equipment to call this number.) These calls are free.
Write	MN Department of Human Services Ombudsperson for Public Managed Health Care Programs PO Box 64249 St. Paul, MN 55164-0249
Email	**dhsombudsman.smhcp@state.mn.us**
Website	**mn.gov/dhs/managedcareombudsman**

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section J Office of Ombudsman for Long Term Care (OOLTC)

The OOLTC helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

OOLTC is not connected with our plan or any insurance company or health plan.

Method	Office of Ombudsman for Long Term Care — Contact information
Call	**1-651-431-2555** (Twin Cities Metro area) Or **1-800-657-3591** (Outside Twin Cities Metro area) The call is free.
TTY	**1-800-627-3529** (You need special telephone equipment to call this number.) Or **711** or use your preferred relay service (You do **not** need special telephone equipment to call this number.) These calls are free.
Write	Minnesota Office of Ombudsman for Long Term Care PO Box 64971 St. Paul, MN 55164-0971
Email	**mba.ooltc@state.mn.us**
Website	**mn.gov/board-on-aging**

Section K Programs to Help People Pay for Their Prescription Drugs

The Medicare.gov website **https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs** provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, as described below.

Section K1 Extra Help

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

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

Section K2 AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance. For information, call the Minnesota Department of Human Services at **651-431-2414** or **800-657-3761**, (TTY **711**).

Note: To be eligible for the ADAP operating in your state, individuals 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, please notify your local ADAP enrollment worker so you can continue to receive assistance for information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Minnesota Department of Human Services at **651-431-2414** or **800-657-3761**, (TTY **711**).

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section L Social Security

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

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

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

Section M Railroad Retirement Board (RRB)

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

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

Chapter 3

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

Introduction

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

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? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section A Information about services and providers

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

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

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

Section B Rules for getting services our plan covers

Our plan covers all services covered by Medicare and Medical Assistance. This includes behavioral health and LTSS.

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

- The care you get must be a **plan benefit.** This means we include it in our Benefits Chart in Chapter 4 of your **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, equipment, or drugs meet accepted standards of medical practice.
  - Medically necessary care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:
    - be the services that other providers would usually order
    - help you get better or stay as well as you are
    - help stop your condition from getting worse
    - help prevent and find health problems

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
  - In most cases, your network PCP must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services. To learn more about referrals, refer to Section D1.
  - You do not need a referral from your PCP for emergency care or urgently needed care or for a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, refer to section D1 in this chapter).
- **You must get your care from network providers.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you will have to pay the provider in full for the services provided. Here are some cases when this rule does not apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to Section H in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. In this situation, we cover the care at no cost to you.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility.
- When you first join the plan, you can continue using the providers you use now for up to 120 days for the following reasons:
  - An acute condition.
  - A life-threatening mental or physical illness.
  - A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year, or is likely to result in death.
  - A disabling or chronic condition that is in an acute phase.
  - You are receiving culturally appropriate health care services (excluding transportation services) and the plan does not have a network provider with special expertise in the delivery of those culturally appropriate health care services.
  - You do not speak English and the plan does not have a network provider who can communicate with you, either directly or through an interpreter.

If your qualified health care provider certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

An exception is made for family planning, which is an open access service covered by us through Medical Assistance. Federal and state laws let you choose any provider, even if not in our network, to get certain family planning services.

This means by any doctor, clinic, hospital, pharmacy, or family planning office. For more information refer to the "Family Planning Services" section of the Benefits Chart in Chapter 4.

Section C Your care coordinator

We use Care Coordinators to make sure you get the best possible care and results. Our care coordinators work with your primary care physician, behavioral health, medical and community service providers to meet your needs. Care Coordination includes developing your care plan, supporting your in your care plan goals and checking with you, your care team, and other plan providers about your care and how it is going.

Section C1 What a care coordinator is

A care coordinator is a person who helps you develop a care plan and coordinates supports and services stated in your care plan. In the development of your care plan, your care coordinator will get to know you and your health and safety concerns. They can help you with your medications, answer health plan questions, supports your health care decisions, help you find providers and arrange home meal delivery and other services for you.

Section C2 How you can contact your care coordinator

If you wish to speak to your Care Coordinator, contact them directly with the contact information they provided you or you may call Member Services at **1-844-368-5888**, TTY: **711** (or your preferred relay service), 8 a.m.–8 p.m. 7 days a week, October–March; Monday–Friday, April–September.

Section C3 How you can change your care coordinator

You may request a change in your Care Coordinator if they are not right for you. Please call Member Services at **1-844-368-5888**, TTY **711** (or your preferred relay service), 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September if you need more information or help in choosing a new Care Coordinator.

Section D Care from providers

Section D1 Care from a primary care provider (PCP)

You must choose a primary care provider (PCP) to provide and manage your care. Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are 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 network physician who is selected by you to provide and coordinate your covered services. PCPs are generally physicians specializing in Internal Medicine, Family Practice or General Practice.

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

Your choice of PCP

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

For a copy of the most recent **Provider and Pharmacy Directory**, or for help in selecting a PCP, call Member Services or visit **myuhc.com/communityplan** for the most up-to-date information about our network providers.

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

Option to change your PCP

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

If you want to change your PCP, call Member Services. If the PCP is accepting additional plan members, the change will become effective on the first day of the following month. You will receive a new UnitedHealthcare member ID card that shows this change.

Services you can get without getting 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 first getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to a network provider (for example, if you're outside our plan's service area or during the weekend).

  NOTE: Urgently needed care must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside of 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 vaccinations, hepatitis B vaccinations, and pneumonia vaccinations 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
- Additionally, if you are 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.

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

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

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

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

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

Section D3 When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we work with you to ensure, that the medically necessary treatment or therapies you are getting continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to Chapter 9 for more information.)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care.

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 Medical Assistance.

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

Section E Long-term services and supports (LTSS)

Long-Term Services and Supports (LTSS) are services that help people who need assistance doing everyday tasks like getting dressed, making food, taking a bath and doing chores. Most of these services help you stay in your home or meet your needs in a nursing home setting.

LTSS must be coordinated through your care coordinator. Your care coordinator will assess your needs, determine if you are eligible, and help complete required forms. If you wish to speak to your Care Coordinator, contact them directly with the contact information they provided you or you may call Member Services at **1-844-368-5888**, TTY **711** (or your preferred relay service), 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September.

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

Your Care Coordinator can help you connect with behavioral health services in your area. You can also use our online tool to locate network providers in your area or call Member Services at **1-844-368-5888**, TTY **711** (or your preferred relay service).

Section G How to get self-directed care

Section G1 What self-directed care is

Consumer Directed Community Support (CDCS) is a service option available to members who are on or qualify for Elderly Waiver. CDCS gives a member flexibility in service planning and responsibility for self-directing his or her services, including hiring and managing support workers. CDCS may include traditional services and goods, and self-designed services.

Section G2 Who can get self-directed care (for example, if it is limited to waiver populations)

This service option is available to members who are on or qualify for Elderly Waiver.

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

If you are interested in CDCS, please contact your care coordinator.

Section H Transportation services

If you need transportation to and from health services that we cover, call **1-888-444-1519**. We will provide the most appropriate and cost-effective mode of transportation. We are not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home or if you choose a specialty provider that is more than 60 miles from your home. Call **1-888-444-1519** if you do not have a Primary Care Clinic that is available within 30 miles of your home and/or if it is over 60 miles to your specialty provider.

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

- serious risk to your health; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part.

If you have a medical emergency:

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

- **As soon as possible, tell our plan about your emergency. We follow up on your emergency care.** You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. Call Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. This phone number is on the back of your ID Card.

Covered services in a medical emergency

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

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

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

Getting emergency care if it wasn't an emergency

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

After the doctor says it wasn't an emergency, we will 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 this care. 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 a severe sore throat that occurs over the weekend and need treatment.

Urgently needed care in our plan's service area

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

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

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

Check your **Provider and Pharmacy Directory** for a list of network Urgent Care Centers or call Member Services at **1-844-368-5888**, TTY **711** (or your preferred relay service), 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September for more information.

Urgently needed care when you are outside our plan's service area

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

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

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 are still entitled to care from our plan.

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

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 of your **Member Handbook** for more information.

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

We do not allow UHC Dual Complete® (HMO D-SNP) providers to bill you for these services. We pay our providers directly, and we protect you from any charges. If a provider sends you a bill instead of sending it to our plan, you should ask us to pay the bill.

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

If you have paid for your covered services or if you have gotten a bill for covered medical services, refer to Chapter 7 of your **Member Handbook** to find out what to do.

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

Our plan covers all services:

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

If you get services that our plan does not 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 will not pay for your services, you have the right to appeal our decision.

Chapter 9 of your **Member Handbook** explains what to do if you want us to cover a medical item or service. 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.

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

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

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

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

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

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

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

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

If you are part of a study that Medicare has **not 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 (**medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf**). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 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 are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is **voluntary and not required** by any federal, state, or local law.
- "Excepted" medical treatment is any care that is **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's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval from us before you are admitted to the facility or your stay will not 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 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 certain items, such as prosthetics.

In this section, we discuss DME you rent. As a member of our plan, however, you usually will not own DME, no matter how long you rent it.

In certain limited situations, we transfer ownership of the DME item to you. Call Member Services to find out about the requirements you must meet and the papers you need to provide.

If you have questions, please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

Section 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.

Note: You can find definitions of Original Medicare and MA Plans in Chapter 12. You can also find more information about them in the **Medicare & You 2024** handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (**medicare.gov/medicare-and-you**) or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

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

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

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

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

Section M3 Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you're a member of our plan, we will cover the following:

- 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.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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 must then provide 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

Introduction

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

Table of Contents

Section A Your covered services

This chapter tells you about services our plan covers. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your **Member Handbook**.

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

If you need help understanding what services are covered, call Member Services at **1-844-368-5888.**

Section A1 During public health emergencies

UHC Dual Complete® (HMO D-SNP) will follow federal and/or state requirements and allowable flexibilities during a declared public health emergency, as applicable. You can call Member Services at the number at the bottom of this page if you have questions.

Section B Rules against providers charging you for services

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

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

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. You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described below.

- We provide covered Medicare and Medical Assistance covered services according to the rules set by Medicare and Medical Assistance.
- The services (including medical care, services, 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.

- Medically necessary care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:
  - be the services, supplies, and prescription drugs that other providers would usually order.
  - help you get better or stay as well as you are.
  - help stop your condition from getting worse.
  - help prevent and find health problems.
- 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.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your **Member Handbook** has more information about using network and out-of-network providers.

When you first join the plan, you can continue using the providers you use now for up to 120 days for the following reasons:

- An acute condition.
- A life-threatening mental or physical illness.
- A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year, or is likely to result in death.
- A disabling or chronic condition that is in an acute phase.
- You are receiving culturally appropriate health care services (excluding transportation services) and the plan does not have a network provider with special expertise in the delivery of those culturally appropriate health care services.
- You do not speak English and the plan does not have a network provider who can communicate with you, either directly or through an interpreter.
- If your qualified health care provider certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- An exception is made for family planning, which is an open access service covered by us through Medical Assistance. Federal and state laws let you choose any provider, even if not in our network, to get certain family planning services. This means by any doctor, clinic, hospital, pharmacy, or family planning office.

All preventive services are free. You will find this apple next to preventive services in the Benefits Chart.

Restricted Recipient Program

- The Restricted Recipient Program is for members who have misused health services. This includes getting health services that members did not need, using them in a way that costs more than they should, or using them in a way that may be dangerous to a member's health. UnitedHealthcare will notify members if they are placed in the Restricted Recipient Program.
- If you are in the Restricted Recipient Program, you must get health services from one designated primary care provider, one clinic, one hospital used by the primary care provider, and one pharmacy. UnitedHealthcare may designate other health care providers. You may also be assigned to a home health agency. You will not be allowed to use the personal care assistance choice or flexible use options or consumer directed services.
- You will be restricted to these designated health care providers for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). All referrals to specialists must be from your primary care provider, and received by the UnitedHealthcare Restricted Recipient Program. Restricted recipients may not pay out-of-pocket to use a non-designated provider who is the same provider type as one of their designated providers.
- Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You will not lose eligibility for MHCP because of placement in the program.
- At the end of the 24 months, your use of health care services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility.
- You have the right to appeal placement in the Restricted Recipient Program. You must file an appeal within 60 days from the date on the notice from us. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. You may request a State Appeal (Medicaid Fair Hearing with the state) after receiving our decision that we will enforce the restriction. Refer to Chapter 9, Section F3, for more information about your right to appeal.

- The Restricted Recipient Program does not apply to Medicare-covered services. If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid medications is not safe, we may limit how you can get those medications. Refer to Chapter 5, Section G3, for more information.

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. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. We may cover additional screenings if medically necessary.	$0
Acupuncture Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing. 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. **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Acupuncture (continued) In addition, we pay for up to 20 units of acupuncture services per calendar year without authorization or ask for prior authorization if additional units are needed for the following: • Acute and chronic pain • Depression • Anxiety • Schizophrenia • Post-traumatic stress syndrome • Insomnia • Smoking cessation • Restless legs syndrome • Menstrual disorders • Xerostomia (dry mouth) associated with the following: – Sjogren's syndrome – radiation therapy • Nausea and vomiting associated with the following: – postoperative procedures – pregnancy – cancer care	$0
Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting (refer to the "Substance use disorder services" section of this chart for additional covered benefits).	$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 life or your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0 *Authorization is required for Non-emergency Medicare-covered ambulance ground and air transportation.* *Emergency Ambulance does not require authorization.*
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 copayment for a routine physical exam each year.
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

Services that our plan pays for	What you must pay
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 they are medically necessary. We will also pay for a doctor to look at and comment on the results.	$0
Breast cancer screening (mammograms) We pay for the following services: • one screening mammogram every 12 months • 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 order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you are eating well. We may cover additional visits if medically necessary.	$0

Services that our plan pays for	What you must pay
Cardiovascular (heart) disease testing We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. The plan pays for care coordination services, including the following: • Assisting you in arranging for, getting, and coordinating assessments, tests, and health and long-term care supports and services • Working with you to develop and update your care plan • Supporting you and communicating with a variety of agencies and persons • Coordinating other services as outlined in your care plan.	$0
Care coordination The plan pays for care coordination services, including the following: • Assisting you in arranging for, getting, and coordinating assessments, tests, and health and long-term care supports and services • Working with you to develop and update your care plan • Supporting you and communicating with a variety of agencies and persons • Coordinating other services as outlined in your care plan	$0
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 We may cover additional services if medically necessary.	$0

Services that our plan pays for	What you must pay
Chiropractic services We pay for the following services: • One evaluation or exam per year • Manual manipulation (adjustment) of the spine to treat subluxation of the spine—up to 24 treatments per calendar year, limited to six per month. • X-rays when needed to support a diagnosis of subluxation of the spine **Note:** Our plan does not cover other adjustments, vitamins, medical supplies, therapies, and equipment from a chiropractor.	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Colorectal cancer screening We pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. 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.	$0

Services that our plan pays for	What you must pay
Dental services Certain dental services, including cleanings, fillings, and dentures, are available through the Medical Assistance Dental Program. Covered Services: • Diagnostic services • Comprehensive exam once every five years (cannot be performed on same date as a periodic or limited evaluation) • Periodic exam (cannot be performed on same date as a limited or comprehensive evaluation) • Limited (problem-focused) exams once per day (cannot be performed on same date as a periodic or comprehensive oral evaluation or dental cleaning service) • Detailed oral evaluation (cannot be performed on same date as full mouth debridement) • Detailed periodontal evaluation (cannot be performed on same date as full mouth debridement) • Teledentistry for diagnostic services • Imaging services, limited to: – Bitewing once per calendar year – Single x-rays for diagnosis of problems four per date of service – Panoramic X-rays once every five years and as medically necessary; once every two years in limited situations; or with a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) procedure – Full mouth X-rays (once in a five-year period) **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Dental services (continued) Preventive services including: • Dental cleanings (limited to twice per calendar year; up to four per year with Prior Authorization) • Fluoride varnish once every six months (cannot be performed on the same date as emergency treatment of dental pain service) • Cavity treatment once per tooth per six months (cannot be performed on the same date as fluoride varnish service of emergency treatment of dental pain service) • Oral hygiene instruction (Authorization is required for additional service) Restorative services including: • Fillings limited to once per 90 days per tooth • Sedative fillings for relief of pain (cannot be performed on same date as emergency treatment of dental pain service) • Individual crowns (must be made of prefabricated stainless steel or resin) (with Prior Authorization) • Endodontics (root canals) (anterior and premolar are limited to once per tooth per lifetime) Periodontics: • Gross removal of plaque and tartar (full mouth debridement) (once per five years) (cannot be performed on same date as dental cleaning service, comprehensive exam, oral evaluation or periodontal evaluation service) • Scaling and root planing (with Prior Authorization) (cannot be performed on same day as dental cleaning or full mouth debridement) (once every two years for each quadrant) • Follow-up procedures (periodontal maintenance) (with Prior Authorization)(every three months/91 days for two years) (up to four per calendar year following the completion of scaling and root planing) **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Dental services (continued) Prosthodontics including: • Removable appliances (dentures and partials, overdentures) once every six years per dental arch • Adjustments, modifications, relines, repairs, and rebases of removable appliances (dentures and partials); repairs to missing or broken teeth are limited to five teeth per 180 days • Replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances • Replacement of partial appliances if the existing partial prosthesis cannot be altered to meet dental needs • Tissue conditioning liners • Precision attachments and repairs Oral surgery: • including extractions (with Prior Authorization) Additional general dental services: • emergency treatment of dental pain • general anesthesia, deep sedation • nitrous oxide • extended care facility/house call in certain institutional settings including: boarding care homes, Institutions for Mental Diseases (IMDs), Intermediate Care Facilities for Persons with Developmental Disabilities(ICF/DDs), Hospices, Minnesota Extended Treatment Options (METO), nursing facilities, school or Head Start program, skilled nursing facilities, and swing beds (a nursing facility bed in a hospital)(cannot be performed on same date as oral hygiene instruction service) • medications (only when medically necessary for very limited conditions) **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Dental services (continued) Additional general dental services: • Behavioral management when necessary to ensure that a covered dental service is correctly and safely performed • Oral bite adjustments (complete adjustments with Prior Authorization) (limited to once per day) **Notes:** If you begin orthodontia services, we will not require completion of the treatment plan in order to pay the provider for services received. If you are new to our health plan and have already started a dental service treatment plan, please contact us for coordination of care. We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.	$0 *Your provider may need to obtain prior authorization for some services*
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. We may cover additional screenings if medically necessary.	$0

Services that our plan pays for	What you must pay
Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months. We may cover additional screenings if medically necessary.	$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 • 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.	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Durable medical equipment (DME) and related supplies Refer to Chapter 12 of your **Member Handbook** for a definition of "Durable medical equipment (DME)." We cover the following items: • Wheelchairs • Crutches • Walkers • Powered mattress systems • Diabetic supplies (For diabetic supplies refer to the "Diabetic self-management training, services, and supplies" section in this benefit chart.) • 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 • Standard curved handle or quad cane and replacement supplies • Cervical traction (over the door) • Bone stimulator • Dialysis care equipment We cover additional items, including: • repairs of medical equipment • batteries for medical equipment • medical supplies you need to take care of your illness, injury or disability • incontinence products • nutritional/enteral products when specific conditions are met • family planning supplies (refer to the "Family planning services" section of this chart for more information) **This benefit is continued on the next page**	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Durable medical equipment (DME) and related supplies (continued) • augmentative communication devices, including electronic tablets Other items may be covered. For diabetic supplies refer to the "Diabetic self-management training, services, and supplies" section in this benefit chart. We pay for all medically necessary DME that Medicare and Medical Assistance usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Elderly Waiver Services (Home and Community-Based Services) The plan will pay for the following services for individuals eligible to get Elderly Waiver (EW) services: • Adult Companion Services: Non-medical care, supervision and socialization. • Adult Day Services (ADS) and ADS Bath: Licensed individualized program of activities to meet the assessed health and social needs of an older adult. ADS Bath is optional. Also includes FADS – Family Adult Day services. • Adult Foster Care: Licensed, adult appropriate residential care and supportive services in a family-like setting. • Case Management: Management of your health and long-term care services among different health and social service professionals. • Chore Services: Heavy household services needed to keep your home clean and safe. • Consumer Directed Community Support Services: Services that you design to meet your needs and manage yourself within a set budget. • Customized Living/24-Hour Customized Living: A group of individualized services (health related and supported services) provided in a qualified setting. • Environmental Accessibility Adaptations: Physical changes to your home and vehicle needed to assure health and safety and enable you to be more independent. • Extended State Plan Home Health Care Services: This includes home health aide and nursing services that are over the Medical Assistance limit. • Extended State Plan Home Care Nursing: This includes home care nursing services that are over the Medical Assistance limit. **This benefit is continued on the next page**	

Services that our plan pays for	What you must pay
Elderly Waiver Services (Home and Community-Based Services) (continued) • Extended State Plan Personal Care Assistance (PCA) Services (Community First Services and Supports (CFSS) replaces PCA services when the State of Minnesota gets Federal approval to provide this service): Help with personal care and activities of daily living (ADLs) over the Medical Assistance limit. PCAs can also assist with instrumental activities of daily living (IALDs) • Family and Caregiver Services: Training, education, coaching and counseling for unpaid caregivers. This includes caregiver training and education, and caregiver counseling. • Home Delivered Meals: An appropriate, nutritionally balanced meal delivered to your home. • Homemaker Services: Services that help you manage general cleaning and household activities. • Individual Community Living Support Services: A bundled service that offers assistance and support to remain in your own home including reminders, cues, intermittent supervision or physical assistance. • Respite Care: Short-term service when you cannot care for yourself, and your unpaid caregiver needs relief. • Specialized Equipment and Supplies: Supplies and equipment that are over the Medical Assistance limit or coverage or are not a part of other Medical Assistance coverage but are specified in your support plan. This includes the Personal Emergency Response System (PERS) • Transitional Services: Items and supports necessary to move from a licensed setting to an independent or semi-independent community-based housing. • Transportation: Enables you to gain access to activities and services in the community. **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Elderly Waiver Services (Home and Community-Based Services) (continued) You must have a MnCHOICES assessment, formerly called a Long-Term Care Consultation (LTCC), done and be found to be nursing home level of care to get these Elderly Waiver (EW) services. You can ask to have this assessment in your home, apartment, or facility where you live. • Your MSHO care coordinator will meet with you and your family to talk about your care needs within 20 days if you call to ask for a visit. • Your MSHO care coordinator will give you information about community services, help you find services to stay in your home or community, and help you find services to move out of a nursing home or other facility. • You have the right to have friends or family present at the visit. You can designate a representative to help you make decisions. You can decide what your needs are and where you want to live. You can ask for services to best meet your needs. You can make the final decisions about your plan for services and help. You can choose who you want to provide the services and supports from those providers available from our plan's network. • After the visit, your MSHO care coordinator will send you a letter that recommends services that best meet your needs. You will be sent a copy of the service or care plan you helped put together. Your MSHO care coordinator will help you file an appeal if you disagree with suggested services or were informed you may not qualify for these services. • People who live on or near the White Earth, Leech Lake, Red Lake, Mille Lacs, or Fond du Lac Reservations may be able to choose to get their EW services through the Tribal health or human services division or through our plan. Contact the tribal nation or our plan if you have questions. **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Elderly Waiver Services (Home and Community-Based Services) (continued) If you are currently on the Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver, you will continue to get services covered by these programs in the same way you get them now. Your county case manager will continue to authorize these services and coordinate with your MSHO care coordinator. If you need transition planning and coordination services to help you move to the community, you may be eligible to get Moving Home Minnesota (MHM) services. MHM services are separate from EW services, but you must be eligible for EW.	$0
Emergency care Emergency care means services that are: • Given by a provider trained to give emergency services, **and** • Needed to treat a medical emergency. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it 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 health; **or** • serious harm to bodily functions; **or** • serious dysfunction of any bodily organ or part This coverage is only available within the U.S. and its territories. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of- network hospital authorized by us. When outside of the United States and its territories, we cover emergency transportation to a nearby medical facility within the foreign country.	$0

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. These are called open access 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/AIDS and other HIV-related conditions • Permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • Genetic counseling **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Family planning services (continued) We will also pay for some other family planning services. However, you must refer to a provider in our provider network for the following services: • Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • Treatment for AIDS and other HIV-related conditions • Genetic testing **Note:** Our plan does not cover artificial ways to become pregnant (artificial insemination, including in vitro fertilization and related services; fertility drugs and related services), reversal of voluntary sterilization, and sterilization of someone under conservatorship or guardianship.	
Fitness program: Renew Active® by UnitedHealthcare® Renew Active by UnitedHealthcare is the gold standard in Medicare fitness programs for body and mind. Renew Active includes: • A free gym membership, access to our national network of gyms and fitness locations, a personalized fitness plan plus thousands of on-demand workout videos and live streaming fitness classes. • An online brain health program with exclusive content for Renew Active members from AARP® Staying Sharp. • Social activities at local health and wellness classes and events. • An online Fitbit® Community for Renew Active. No Fitbit device is needed. • 1 at-home fitness kit for members 15 miles or more from a participating fitness center. 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
Health services The plan will pay for the following services: • Advanced Practice Nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist • Allergy immunotherapy and allergy testing • Behavioral Health Home: coordination of primary care, mental health services and social services • Clinical trial coverage – Routine care that is provided as part of the protocol treatment of a clinical trial; is usual, customary, and appropriate to your condition; and would typically be provided outside of a clinical trial. – This includes services and items needed for the treatment of effects and complications of the protocol treatment. – For more information, please refer to Chapter 3 of your **Member Handbook** • Community health worker care coordination and patient education services • Community Medical Emergency Technician (CMET) services – Post-hospital/post-nursing home discharge visits ordered by your primary care provider – Safety evaluation visits ordered by your primary care provider **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Health services (continued) • Community Paramedic: certain services provided by a community paramedic. The services must be a part of a care plan ordered by your primary care provider. The services may include: – Health assessments – Chronic disease monitoring and education – Help with medications – Immunizations and vaccinations – Collecting lab specimens – Follow-up care after being treated at a hospital – Other minor medical procedures • Home visits to determine if there are asthma-triggers in the member's home must be provided by a registered environmental health specialist, healthy homes specialist, and lead risk assessor. Your local public health agency can help you find one of these health care professionals to help you or you can contact Member Services. • Hospital In-Reach Community-Based Service Coordination (IRSC): coordination of services targeted at reducing hospital emergency room (ER) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ER and other health care services. • Services of a certified health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit • Telemonitoring: use of special equipment to send health data to providers from a remote location, like a member's home. Providers use telemonitoring to help manage complex health care without the need for the member to be in a clinic or hospital. • Tuberculosis care management and direct observation of drug intake	$0

Services that our plan pays for	What you must pay
Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We cover additional items and services, including: • Hearing aids and batteries • Repair and replacement of hearing aids due to normal wear and tear, with limits	$0 Provided by: Plan network providers in your service area
Hearing services — routine hearing exam We cover 1 hearing exam every year. Other hearing exam providers are available in the UnitedHealthcare network. The plan only covers hearing aids from a UnitedHealthcare Hearing network provider.	$0
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. Additional benefits may be covered by us.	$0

Services that our plan pays for	What you must pay
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies • Respiratory therapy • Home Care Nursing (HCN) • Personal care assistant (PCA) services and supervision of PCA services (Community First Services and Supports (CFSS) replaces PCA services when the State of Minnesota gets Federal approval to provide this service.)	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Home infusion therapy Our plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; **and** • Supplies, such as tubing or a catheter. Our plan covers home infusion services that include but are not limited to: • Professional services, including nursing services, provided in accordance with your care plan; • 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.	$0

Services that our plan pays for	What you must pay
Home support services With this benefit, you get a quarterly credit to spend on home and bath safety devices and extra support at home. Credits are added to your account every quarter and expire at the end of the year. Covered services include: • Companionship • Meal prep • Pest control • Home repair • Home modification • Errands • Respite • Intermittent yard maintenance • Snow removal You can get more information by viewing the Vendor Information Sheet at **myuhc.com/communityplan** or by calling Customer Service to have a paper copy sent to you. Quarterly credit for home and bath safety devices and extra support at home is $150.	

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. We must help you find Medicare-certified hospice programs in the plan's service area. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs to treat symptoms and pain • Short-term respite care • Home care **Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Refer to Section F of this chapter for more information. **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 nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 of your **Member Handbook**. **Note:** If you need non-hospice care, you should call your care coordinator and/or Member Services to arrange the services. Non-hospice care is care that is **not** related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.	$0

Services that our plan pays for	What you must pay
Housing stabilization services The plan will pay for the following services for members eligible for Housing Stabilization Services: • Housing consultation services to develop a person-centered plan for people without Medical Assistance case management services • Housing transition services to help you plan for, find, and move into housing • Housing transition — moving expenses (limited to $3,000 per year) – Only for people leaving a Medical Assistance funded institution of provider controlled setting that are moving into their own home. – Applications, security deposits, and the cost of securing documentation that is required to obtain a lease on an apartment or home – Essential household furnishings required to live in and use a community-home, including furniture, window coverings, food preparation items, and bed/bath linens – Set up fees or deposits for utility or service access, including telephone, electricity, heating and water – Services necessary for the individual' health and safety such as pest removal and one time cleaning prior to moving in – Necessary home accessibility adaptations • Housing sustaining services to help you maintain housing • Transportation to get housing stabilization services (within a 60 mile radius) You must have a Housing Stabilization Services eligibility assessment done and be found eligible for these services. If you need Housing Stabilization Services, you can ask for an assessment or be supported by your provider or case manager. **This benefit is continued on the next page**	$0 *You may need to obtain prior authorization*

Services that our plan pays for	What you must pay
Housing stabilization services (continued) If you have a targeted case manager or waiver case manager or senior care coordinator, that case manager can support you in accessing services, or you can contact a Housing Stabilization Services provider directly to help you. Department of Human Services (DHS) staff will use the results of the assessment to determine whether you meet the needs-based criteria to get this service. DHS will send you a letter of approval or denial for Housing Stabilization Services.	
Immunizations We pay for the following services: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of your **Member Handbook** to learn more.	$0

Services that our plan pays for	What you must pay
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: • Semi-private room (or a private room if it is 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 use disorder 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. For heart transplants this also includes a Ventricular Assist Device inserted as a bridge or as a destination therapy treatment. **This benefit is continued on the next page**	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized. *Your provider must obtain prior authorization*

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 are a candidate for a transplant. Transplant providers may be local or outside of the service area. • Blood, including storage and administration • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are you a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!". This fact sheet is available on the Web at **medicare.gov/sites/default/files/2021-10/11435-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.	
Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay, including extended psychiatric inpatient hospital stays. Covered services include: • Mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. • Inpatient substance abuse services	$0 Y*our provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We do not pay for your inpatient stay if you have used all of your inpatient benefit or if the stay is not reasonable and medically necessary. However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact 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
Interpreter services The plan will pay for the following services: • Spoken language interpreter services • Sign language interpreter services	$0

Services that our plan pays for	What you must pay
Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of your **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. Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.	$0 *Your provider may need to obtain prior authorization for some services*
Lung cancer screening Our plan pays for lung cancer screening every 12 months if you: • Are aged 50-77, **and** • Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.	$0

Services that our plan pays for	What you must pay
Meal Benefit This benefit can be used immediately following an inpatient hospital or skilled nursing facility (SNF) stay if recommended by a provider. **Benefit guidelines** • Receive up to 28 home-delivered meals for up to 14 days • First meal delivery may take up to 72 hours after ordered • Some restrictions and limitations may apply	$0 Provided by: Roots Food Group Prior authorization is required.
Medical Assistance covered prescription drugs We cover some drugs under Medical Assistance that are not covered by Medicare Part B and Medicare Part D. These include some over-the-counter products, some prescription cough and cold medicines and some vitamins. The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor shows us that: • the drug that is normally covered has caused a harmful reaction to you; **or** • there is a reason to believe the drug that is normally covered would cause a harmful reaction; **or** • the drug prescribed by your doctor is more effective for you than the drug that is normally covered. The drug must be in a class of drugs that is covered. If pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by our plan. If the pharmacy won't call your doctor, you can. You can also call Member Services at the number at the bottom of this page.	$0

Services that our plan pays for	What you must pay
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. 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 cover additional benefits if medically necessary.	$0
Medicare Diabetes Prevention Program (MDPP) Our plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0

Services that our plan pays for	What you must pay
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or Ambulatory Surgical Center (ASC) services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit. Chapter 5 of your **Member Handbook** explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6 of your **Member Handbook** explains what you pay for your outpatient prescription drugs through our plan.	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Mental health services Refer to the following sections for covered mental health services: • Depression screening • Inpatient mental health care • Outpatient mental health care • Partial hospitalization services	$0
Nurse Hotline Nurse Hotline services available, 24 hours a day, 7 days a week. Speak to a registered nurse (RN) about your medical concerns and questions. You can view the Vendor Information Sheet at **myuhc.com/communityplan** or call Member Services to have a paper copy sent to you.	$0 Provided by: NurseLine

Services that our plan pays for	What you must pay
Nursing facility care We are responsible for paying a total of 180 days of nursing home room and board. This includes custodial care. If you need continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for your care. If DHS is currently paying for your care in the nursing home, DHS, not our plan, will continue to pay for your care. Refer to the "Skilled nursing facility (SNF) care" section of this chart for more information about the additional nursing home coverage the plan provides. A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital. Services that we pay for include, but are not 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 **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Nursing facility care (continued) • Dental services, including dentures • Vision benefits • Hearing exams • Chiropractic care • Podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • A nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • A nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we will 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. We may cover additional benefits if medically necessary.	$0

Services that our plan pays for	What you must pay
Obstetrics and Gynecology (OB/GYN) Services Covered Services: • Prenatal, delivery, and postpartum care • Childbirth classes • HIV counseling and testing for pregnant people — open access service • Treatment for HIV-positive pregnant people • Testing and treatment of sexually transmitted diseases (STDs) — open access service • Pregnancy-related services received in connection with an abortion (does not include abortion-related services) • Doula services by a certified doula supervised by either a physician, nurse practitioner, or certified nurse midwife and registered with the Minnesota Department of Health (MDH) • Services provided by a licensed health professional at licensed birth centers, including services of certified nurse midwives and licensed traditional midwives Not Covered Services: • Abortion: This service is not covered under the Plan. It may be covered by the state. Call the Minnesota Health Care Programs Member Helpdesk at **651-431-2670** or **1-800-657-3739** (toll free) or **711** (TTY) or use your preferred relay service. Also refer to Section 9. • Planned home births You have "direct access" to OB-GYN providers for the following services: annual preventive health exam, including follow-up exams that your qualified health care provider says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services, you must go to a provider in the Plan network. For services labeled as open access, you can go to any qualified health care provider clinic, hospital, pharmacy, or family planning agency.	

Services that our plan pays for	What you must pay
Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD): • Intake activities • Periodic assessments • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs, chemicals, or substances in your body (toxicology testing)	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Food, over-the-counter (OTC) and utility bill credit With this benefit, you'll get a credit loaded to your UnitedHealthcare UCard® each month to pay for covered groceries, OTC items and certain utility bills. Unused credits expire at the end of each month. Covered items include: • Healthy foods like fruits, vegetables, meat, seafood, dairy products, water and more. • Brand name and generic OTC products, like vitamins, pain relievers, toothpaste, cough drops and more. • Eligible utility bills like electricity, gas, water and internet. The service address must match an address we have on file for you. The credit cannot be used to buy tobacco or alcohol. You can use your credit at thousands of participating stores or place an order online or over the phone through your catalog. Order online at **myuhc.com/communityplan** with minimum order of $35 and free standard shipping. To receive a paper catalog, call Member Services or the number on the Vendor Information Sheet. You can also use your credit to pay eligible utility bills online, over the phone or at your local Walmart MoneyCenter or Customer Service Desk. Visit the UCard® Hub at **myuhc.com/CommunityPlan** to find participating stores, check your balance, place an order online or pay utility bills. **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.	$0 copayment Provided by: Solutran Monthly credit is $180

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 maybe other 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 • Other outpatient diagnostic tests	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **medicare.gov/sites/default/files/2021-10/11435-Inpatientor-Outpatient.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week. Outpatient observation is explained in Outpatient surgery and other medical services provided at hospital outpatient facilities and ambulatory surgical centers.	

Services that our plan pays for	What you must pay
Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services – Observation services help your doctor know if you need to be admitted to the hospital as an "inpatient." – Sometimes you can be in the hospital overnight and still be an "outpatient." – You can get more information about being an inpatient or an outpatient in this fact sheet: **medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself	$0 *Your provider may need to obtain prior authorization*

Services that our plan pays for	What you must pay
Outpatient mental health care We pay for mental health services provided by any of the following: • 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) • a Tribal Nations certified professional • a mental health rehabilitative professional • any other Medicare-qualified mental health care professional as allowed under applicable state laws The plan will pay for the following services, and maybe other services not listed here: • Certified Community Behavioral Health Clinic (CCBHC) • Clinical care consultation • Crisis response services including screening, assessment, intervention, stabilization (including residential stabilization), and community intervention • Diagnostic assessments including screening for presence of co-occurring mental illness and substance use disorders **This benefit is continued on the next page**	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Outpatient mental health care (continued) • Dialectical Behavioral Therapy (DBT) • Intensive Outpatient Program (IOP) • Mental health provider travel time • Mental Health Targeted Case Management (MH-TCM) • Forensic Assertive Community Treatment (FACT) • Outpatient mental health services, including explanation of findings, mental health medication management, neuropsychological services, psychotherapy (patient and/or family, family, crisis and group), and psychological testing • Physician Mental Health Services, including health and behavioral assessment/intervention, inpatient visits, psychiatric consultations to primary care providers, and physician consultation, evaluation, and management • Rehabilitative Mental Health Services, including Assertive Community Treatment (ACT), Adult day treatment, Adult Rehabilitative Mental Health Services (ARMHS), Certified Peer Specialist (CPS) support services in limited situations, Intensive Residential Treatment Services (IRTS), and Partial Hospitalization Program (PHP) • Telemedicine If we decide no structured mental health treatment is necessary, you may get a second opinion. For the second opinion, we must allow you to use any qualified health professional that is not in the plan network. We will pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision. We will not determine medical necessity for court-ordered mental health services. Use a plan network provider for your court-ordered mental health assessment.	$0 *Your provider must obtain prior authorization* Virtual visits may require video-enabled smartphone or other device. Not for use in emergencies. Not all network providers offer virtual care.

Services that our plan pays for	What you must pay
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 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Outpatient substance abuse services We pay for the following services, and maybe other services not listed here: • Alcohol misuse screening and counseling including Screening Brief Intervention Referral to Treatment (SBIRT) authorized services and comprehensive assessments • 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 • Outpatient medication assisted treatment • Substance use disorder treatment coordination • Peer recovery support • Detoxification (only when inpatient hospitalization is medically necessary because on conditions resulting from injury or medical complications during detoxification) • Withdrawal management A qualified professional who is part of the Plan network will make recommendations for substance use disorder services for you. You may elect up to the highest level of care recommended by the qualified professional. You may receive an additional assessment at any point throughout your care, if you do not agree with the recommended services. If you agree with the second assessment, you may access services according to substance use disorder standards and the second assessment You have the right to appeal. Refer to Chapter 9.	
Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and Ambulatory Surgical Centers (ASCs).	$0 *Your provider must obtain prior authorization*

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Services that our plan pays for	What you must pay
Partial hospitalization services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.	$0 *Your provider must obtain prior authorization*
Personal Emergency Response System With a Personal Emergency Response System (PERS), help is only a button press away. A PERS device can quickly connect you to the help you need, 24 hours a day in any situation. It's a lightweight, discreet button that can be worn on your wrist or as a pendant. It's also safe to wear in the shower or bath. Depending on the model you choose, it may even automatically detect falls. You must have a working landline or live in an area that has AT&T wireless coverage to get a PERS device. The cellular device works nationally with the AT&T wireless network, but does not require you to have AT&T coverage. You can view the Vendor Information Sheet at **myuhc.com/communityplan** or call Member Services to have a paper copy sent to you.	$0 Provided by: Lifeline

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits We pay for the following services: • Medically necessary health care or surgery services given in places such as: – physician's office – certified Ambulatory Surgical Center – hospital outpatient department • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams given by your primary care provider, if your doctor orders them to find out whether you need treatment • 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 or Medical Assistance • 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 the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Telehealth services for members with a substance use disorder or co-occurring mental health disorder • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: – You have an in-person visit within 6 months prior to your first telehealth visit – You have an in-person visit every 12 months while receiving these telehealth services – Exceptions can be made to the above for certain circumstances **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) • 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 before surgery • Non-routine dental care. Covered services are limited to: – surgery of the jaw or related structures, – setting fractures of the jaw or facial bones, – pulling teeth before radiation treatments of neoplastic cancer, **or** – services that would be covered when provided by a physician. • For information about other dental services we cover, refer to the "Dental services" section of this chart. • Preventive and physical exams • Family Planning services. For more information, refer to the "Family planning" section of this chart. **This benefit is continued on the next page**	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits (continued) • Certain telehealth services, including: – Additional Virtual Medical Visits: • Urgently Needed Services • Primary Care Provider • Specialist • Other Health Care Professionals – Other types of Virtual Medical Visits: • Cardiac Rehabilitation Services • Intensive Cardiac Rehabilitation Services • Outpatient Rehabilitation Services • Occupational Therapy • Physical Therapy and Speech-Language Therapy – Additional Mental Health telehealth visits: • Covered services include individual mental health services • Virtual Mental Health Visits are mental health visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/video capabilities. Visit **virtualvisitsmentalhealth.uhc.com** to learn more and schedule a virtual appointment. – You have the option of receiving getting these services either through an in-person visit or via by telehealth. If you choose to receive get one of these services via by telehealth, then you must use a network provider that currently who offers the service via by telehealth. • Virtual Medical Visits are medical visits delivered to you outside of medical facilities by network providers that have appropriate online technology and live audio/video capabilities to conduct the visit. • Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment.	$0 *Your provider may need to obtain prior authorization for some services*

Services that our plan pays for	What you must pay
Podiatry services We pay for the following services: • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members when medically necessary including conditions affecting the legs, such as diabetes • Other non-routine foot care such as debridement of toenails and infected corns and calluses **Additional routine foot care** We cover 6 routine foot care visits every year. This benefit is in addition to the Medicare-covered podiatry services benefit listed above. Covered services include treatment of the foot which is generally considered preventive, i.e., cutting or removal of corns, warts, calluses or nails.	$0 *Authorization is required for Medicare-covered podiatry. Routine foot care visits do not require authorization.*
Prostate cancer screening exams For men, 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 devices and related supplies Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here: • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Orthotics • Wigs for people with hair loss due to any medical condition • Some shoes when a part of a leg brace or when custom molded. We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.	$0 *Your provider must obtain prior authorization*
Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Routine transportation Details of this benefit: • UHC Dual Complete® (HMO D-SNP) offers 48 one-way trips to or from approved locations which are covered each year (limited to ground transportation only) in addition to what is covered under Medical Assistance. • We will not limit transportation trips to medical appointments and pharmacies under Medical Assistance. • 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 60 miles of driving distance. A trip is one-way transportation; a round trip is 2 trips. • Transportation services must be requested 3 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 or door-to-door service. • Wheelchair vans may be available upon request. • Drivers do not have medical training. In case of emergency, call **911**. • Routine transportation not for use in emergencies. Under Medicare, this benefit does not cover transportation by: • Stretcher • Ambulance; you may be able to qualify for these modes under Medical Assistance. You can get more information on non-emergent medical transportation by calling Member Services at **1-844-368-5888**.	$0

Services that our plan pays for	What you must pay
AbleTo Self-help mobile digital application that focuses on empowering individuals in improving their mental health, through interaction with their smart phone application tools and activities.	$0

Services that our plan pays for	What you must pay
Second Harvest Heartland FOODRx program As part of our efforts to connect the full resources of our community with our food insecure enrollees, we will partner with Second Harvest Heartland to provide a food prescription program for subset of members with chronic conditions and/or those who recently experienced an inpatient stay. Core components of the program include tools for a healthier lifestyle change with clinically tailored and culturally specific meals, a local engagement coordinator for proactive monthly outreach to members, and tracking and evaluation of program metrics related to member outreach, enrollment and persistence within the program. Particularly for the seniors population, the programs' member outreach component serves to mediate social isolation and loneliness, providing an opportunity for members to regularly connect with trained Second Harvest staff. The FOODRx program also includes SNAP referral and assistance, ensuring members will have access to healthy foods after the six-month programs end. Although Second Harvest is based in the Metro area, we have teamed up with them and their delivery vendor to provide this benefit statewide. • FOODRx Chronic Disease Box with Produce Add-on: Members with diabetes and other chronic conditions participating in this program will receive 25 culturally tailored meals provided monthly and delivered to their doorstep (no transportation barrier to receiving food) for six months. In each box, enrollees receive education materials related to living with chronic disease and recipes to assist with selecting and preparing healthy food. FOODRx boxes are available in two culturally tailored cuisines, American and Hispanic, with a third vegetarian option for those whose cultural, religious, or personal dietary practices call for it. Enrollees can choose different cuisines each month (e.g., vegetarian the first month, Hispanic the second month and so on). In addition, to supplement the shelf-stable food provided in the FOODRx box, enrollees will receive a separate box of fresh, local produce each month for the six-month program. This additional box of produce not only allows members to cook more nutritionally-balanced meals, but also allows them to make culturally-aligned meals that require fresh fruits and vegetables. State eligibility requirements may apply.	$0

Services that our plan pays for	What you must pay
Seeking Safety Seeking Safety is a manual based model that helps individuals dealing with trauma/PTSD and substance abuse establish safety in their lives. Seeking Safety applies 25 coping skills to help attain and maintain safety in relationships, thinking, behaviors and emotions.	$0
Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0

Services that our plan pays for	What you must pay
Skilled nursing facility (SNF) care (continued) For additional nursing home services covered by us, refer to the "Nursing facility care" section. We pay for the following services, and maybe other services not listed here: • A semi-private room, or a private room if it is medically necessary • Meals, including special diets • 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 • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • A nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • A nursing facility where your spouse or domestic partner lives at the time you leave the hospital	$0 *Your provider must obtain prior authorization*

Services that our plan pays for	What you must pay
Smoking and tobacco use cessation If you use tobacco but do not have signs or symptoms of tobacco-related disease, and want or need to quit: • We will 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. We may cover additional benefits if medically necessary.	$0
Substance use disorder services The plan pays for the following services: • Screening/assessment/diagnosis • Outpatient treatment • Inpatient hospital • Residential non-hospital treatment • Outpatient methadone treatment • Substance use disorder treatment coordination • Peer recovery support • Detoxification (only when inpatient hospitalization is medically necessary because of conditions resulting from injury or medical complications during detoxification) • Withdrawal management **This benefit is continued on the next page**	$0

Services that our plan pays for	What you must pay
Substance use disorder services (continued) A qualified assessor who is a part of our plan's network will decide what type of substance use disorder care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor We will do this within five working days of when we get your request. If you agree with the second assessment, you may access services according to substance use disorder standards and the second assessment. You have the right to appeal. Refer to Chapter 9 of your **Member Handbook**.	$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 will pay 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
Transportation If you need transportation to and from health services that we cover, call **1-888-444-1519**. We will provide the most appropriate and cost-effective mode of transportation. Our plan is not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home or if you choose a specialty provider that is more than 60 miles from your home. Call **1-844-368-5888** if you do not have a Primary Care Clinic that is available within 30 miles of your home and/or you do not have a specialty provider that is available within 60 miles of your home. • Non-emergency ambulance • Volunteer driver transport • Unassisted transport (taxi or public transportation) • Assisted transportation • Lift-equipped/ramp transport • Protected transportation • Stretcher transport **Note:** Our plan does not cover mileage reimbursement (for example, when you use your own car), meals, lodging, and parking, also including out of state travel. These services are not covered under the plan but may be available through the local county or tribal agency. Call your local county or tribal agency for more information.	$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** • a sudden medical illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider because given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency). Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our customer service number for more information. This coverage is only available within the U.S. and its territories.	$0
Virtual Mental Health Visits Virtual Mental Health Visits are mental health visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/video capabilities. Visit **virtualvisitsmentalhealth.uhc.com** to learn more and schedule a virtual appointment. Covered services include individual mental health services. Not all conditions can be treated through virtual visits. The virtual visit provider will identify if you need to see an in-person provider for treatment.	$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, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. For people at high risk of glaucoma, the plan will 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, **and** • Hispanic Americans. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery. We also cover the following: • Eye exams • Initial eyeglasses, when medically necessary. Selection may be limited. • Replacement eyeglasses, when medically necessary. Identical replacement of covered eyeglasses for loss, theft, or damage beyond repair. • Repairs to frames and lenses for eyeglasses covered under the plan • Tinted, photochromatic (such as Transitions®) lenses, or polarized lenses, when medically necessary • Contact lenses, when medically necessary under certain circumstances	$0 *Your provider may need to obtain prior authorization for some services*

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Services that our plan pays for	What you must pay
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **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
White Bison White Bison offers sobriety, recovery, addiction prevention, and wellness/Wellbriety learning resources to the Native American/Alaska Native community nationwide. Eligibility requirements apply.	$0

Section E Benefits covered outside of our plan

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

Section E1 Hospice care

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

Refer to the 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 Medicare Part B that relate to your terminal prognosis:

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

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

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

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

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

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

Section E2 Other Services

The following services are not covered by us under the plan but may be available through another source, such as the state, county, federal government, or tribe. To find out more about these services, call the Minnesota Health Care Programs Member Helpdesk at **651-431-2670** or **1-800-657-3739** (toll-free). TTY users should call **1-800-627-3529**.

- Case management for people with developmental disabilities
- Intermediate care facility for people who have a developmental disability (ICF/DD)
- Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
- Room and board associated with Intensive Residential Treatment Services (IRTS)
- Services provided by a state regional treatment center or a state-owned long-term care facility unless approved by us or the service is ordered by a court under conditions specified in law
- Services provided by federal institutions
- Except Elderly Waiver services, other waiver services provided under Home and Community-Based Services waivers
- Job training and educational services
- Day training and habilitation
- Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
- Nursing home stays for which our plan is not otherwise responsible. (Refer to the "Nursing facility care" and the "Skilled nursing facility (SNF) care" sections in the Benefits Chart for additional information.)
- Vulnerable Adult Protective Services
- Medical Assistance covered services provided by Federally Qualified Health Centers (FQHCs)

Section F Benefits not covered by our plan, Medicare, or Medical Assistance

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

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

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

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medical Assistance, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Refer to Chapter 3 of your **Member Handbook** for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically necessary and Medicare and/or Medical Assistance pays for it.
- A private room in a hospital, except when it is medically necessary.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Fees charged by your immediate relatives or members of your household. Exceptions to this may be for some services, such as personal care assistance (PCA) and consumer-directed community supports (CDCS) services.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Routine foot care, except as described in Podiatry services in the Benefits Chart in Section D.
- Radial keratotomy, LASIK surgery, and other low-vision aids.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Chapter 5

Getting your outpatient prescription drugs

Introduction

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

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

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

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section. If a drug is a Part D drug, it cannot be covered under the Medical Assistance benefit.

1. You must have a doctor or other provider 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.
2. Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
3. You generally must use a network pharmacy to fill your prescription.
4. Your prescribed drug must be on the plan's **List of Covered Drugs**. We call it the "Drug List" for short.
   - If it is not on the Drug List, we may be able to cover it by giving you an exception.
   - Refer to Chapter 9, Section D3, to learn about asking for an exception.
5. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your doctor may be able to help identify medical references to support the requested use of the prescribed drug.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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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.

To find a network pharmacy, look in the **Provider and Pharmacy Directory**, visit our website, or contact Member Services at the number at the bottom of this page or your care coordinator.

Section A2 Using your Member ID Card when you fill a prescription

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

If you do not have your Member ID Card 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. If you cannot pay for the drug, contact Member Services right away. We will do what we can to help.

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

Section A3 What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can 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 care coordinator.

Section A4 What to do if your pharmacy leaves the network

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

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

Section A5 Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy is not in our network, or you have any difficulty getting your drugs in a long-term care facility, please 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 that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

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

Section A6 Using mail-order services to get your drugs

Our plan's mail-order service allows you to order up to a 30-day supply.

Filling prescriptions by mail

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

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

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

Mail-order processes

The 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.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

   The pharmacy will automatically fill and deliver new prescriptions it gets from you.

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

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

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

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

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

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

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

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

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

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

   To opt out of our program that automatically prepares mail-order refills, please contact the mail order pharmacy.

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

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section A7 Getting a long-term supply of drugs

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

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 100-day supply has the same copay as a 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 Member Services or your Care Coordinator for more information.

For certain kinds of drugs, 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.

Optum Home Delivery is a service of Optum Rx, a home delivery pharmacy, pharmacy benefit manager and affiliate of UnitedHealthcare Insurance Company. You are not required to use Optum Rx for your maintenance medications. Other pharmacies are available in your network.

Section A8 Using a pharmacy not in our network

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

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

- **Prescriptions for a medical emergency**
  We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Formulary without restrictions, and are not excluded from Medicare Part D coverage.
- **Coverage when traveling or out of the service area**
  If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network preferred mail service pharmacy or through our other network pharmacies. Contact Member Services to find out about ordering your prescription drugs ahead of time.
- If you are unable to obtain a covered drug in a timely manner within the service area because a network pharmacy is not within reasonable driving distance that provides 24-hour service.
- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or 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.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

In these cases, check first with Member Services first to find out if there is a network pharmacy nearby.

Section A9 Paying you back for a prescription

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

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

NOTE: If the drug is covered by Medical Assistance, we do not allow UHC Dual Complete® (HMO D-SNP) providers to bill you for these drugs. 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. If you paid for a drug that you think we should have covered, contact Member Services at the number at the bottom of this page.

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

Section B1 Drugs on the 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 Medical Assistance.

Our Drug List includes brand name drugs and generic drugs.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the 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. Generally, generics work just as well as brand name drugs and usually cost less. There are generic drug substitutes available for many brand name drugs. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

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

Section B2 How to find a drug on the Drug List

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

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

Section B3 Drugs not on the Drug List

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

Our plan does not pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to Chapter 9 of your **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 Medical Assistance drugs) cannot pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called "off-label use." Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, Medicare or Medical Assistance cannot cover the types of drugs listed below.

- Drugs used to promote fertility.
- Drugs used for cosmetic purposes or to promote hair growth.

- Drugs used for the treatment of sexual or erectile dysfunction.
- Outpatient drugs made by a company that says you must have tests or services done only by them.

Section B4 Drug List tiers

Every drug on our plan's Drug List is in a cost-sharing tier level. What you pay for a drug on the Drug List depends on whether the drug is a generic or brand name drug. Tier 1 generic drugs have the lowest copay. Tier 1 brand name drugs have a higher copay. Over-the-counter drugs and products have a $0 copay.

To find out the cost-sharing for your drug, look for the drug in our plan's Drug List.

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

Section C Limits on some drugs

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

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

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

1. **Limiting use of a brand name drug when a generic version is available**

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

   - We usually do not pay for the brand name drug when there is a generic version.
   - However, if your provider told us the medical reason that the generic drug, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

2. **Getting plan approval in advance**

   For some drugs, you or your doctor must get approval from our plan before you fill your prescription. If you don't get approval, we may not cover the drug.

3. **Trying a different drug first**

   In general, we want you to try lower-cost drugs (that often are as effective) before the plan covers 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, the plan may require you to try Drug A first.

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

4. **Quantity limits**

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

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services or check our website at **myuhc.com/communityplan**. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to Chapter 9 of the **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 might 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 (Limits on some drugs), some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

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

Section D1 Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our Drug List or when it 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 have been taking:
   - is no longer on our Drug List, **or**

- was never on our Drug List, **or**
- is now limited in some way.

2. You must be in one of these situations:
   - You were in our plan last year.
     - We cover a temporary supply of your drug **during the first 90 days of the calendar year**.
     - This temporary supply is for up to 30 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
   - You are new to our plan.
     - We cover a temporary supply of your **drug during the first 90 days of your membership in the plan.**
     - This temporary supply is for up to 30 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
   - You have been in the 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.

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

Section D3 Asking for an exception

If a drug you are taking 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).

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

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

Section E Coverage changes for your drugs

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

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

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

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

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

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

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

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

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

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

  – We may not tell you before we make this change, but we will 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 will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9 of your **Member Handbook** for more information on exceptions.

- **A drug is taken off the market.** If the FDA says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we take it off our Drug List. If you are taking the drug, we will tell you. Your prescriber will also know about this change and can work with you to find another drug for your condition.

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

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

When these changes happen, we:

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

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

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

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

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

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section F Drug coverage in special cases

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

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

Section F2 In a long-term care facility

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

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

Section F3 In a Medicare-certified hospice program

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

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

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice. Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to Chapter 4 of your **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

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

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

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

Section G2 Programs to help you manage your drugs

Our plan has a program to help 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 will give you:

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

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

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

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

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

Section G3 Drug management program for safe use of opioid medications

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

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

- Requiring you to get all prescriptions for those medications **from a certain pharmacy** and/or **from a certain doctor**
- **Limiting the amount** of those medications we cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

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

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to Chapter 9 of your **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 Medical Assistance prescription drugs

Introduction

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

- Medicare Part D prescription drugs, **and**
- Drugs and items covered under Medical Assistance, **and**
- Drugs and items covered by the plan as additional benefits.

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

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

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

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

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

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

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Section A The Explanation of Benefits (EOB)

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

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

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

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

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count towards your total out-of-pocket costs.
- We also pay for some over-the-counter drugs. You do not have to pay anything for these 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 Medical Assistance. These drugs are included in the Drug List.

Section B How to keep track of your drug costs

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

1. **Use your Member ID Card.**

   Show your Member ID Card 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.**

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

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

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

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

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

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

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

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

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

   For more information, you can call UHC Dual Complete® (HMO D-SNP) Member Services or read your UHC Dual Complete® (HMO D-SNP) **Member Handbook** at **myuhc.com/communityplan**.

   What if you find mistakes on this summary?

   If something is confusing or doesn't seem right on this EOB, please call UHC Dual Complete® (HMO D-SNP) Member Services. You can also find answers to many questions on our website: **myuhc.com/communityplan**.

   What about possible fraud?

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

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

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

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

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

Section C1 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 your **Member Handbook** to find out when we do that.
- A mail-order pharmacy.

Refer to Chapter 9 of the **Member Handbook** to learn about how to file an appeal if you are told a drug will not be covered. To learn more about these pharmacy choices, refer to Chapter 5 of your **Member Handbook** and our **Provider and Pharmacy Directory**.

Section C2 Getting a long-term supply of a drug

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

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

Section D Vaccinations

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

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.

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

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

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

- We can tell you about how our plan covers your vaccination

Section D2 What you pay for a vaccination covered by Medicare Part D

What you pay for a vaccination depends on the type of vaccine (what you are 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 your **Member Handbook**.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. If the vaccine is recommended for adults by an organization called the **Advisory Committee or Immunization Practices (ACIP)** then the vaccine will cost you nothing.

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

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
   - For most adult Part D vaccines, you will pay nothing.
   - For other Part D vaccines, you pay nothing for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
   - You pay nothing 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 will pay nothing for the vaccine itself.
   - For other Part D vaccines, you pay nothing for the vaccine.
   - Our plan pays for the cost of giving you the shot.

Chapter 7

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

Introduction

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

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Section A Asking us to pay for your services or drugs

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

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

If you get a bill for health care or drugs, do not pay the bill and send the bill to us. To send us a bill, refer to Section B of this chapter (Sending a request for payment).

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid, it is your right to be paid back.
  - If you paid for services covered by Medicare, it is your right to be paid back.
  - If you paid for services covered by Medical Assistance we can't pay you back, but the provider will. Member Services can help you contact the provider's office. Refer to the bottom of the page for the Member Services phone number.
- If we do not cover the services or drugs, we will tell you.

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

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

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

   Ask the provider to bill us.

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

   Network providers must always bill us. It's important to show your Member ID Card 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 at the number at the bottom of this page if you get any bills.**

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

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

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

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

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

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

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

5. **When you pay the full prescription cost because you don’t have your Member ID Card with you**

   If you don’t have your Member ID Card 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 Member ID Card.
   - Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for the drug.

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

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

   - The drug may not be on our **List of Covered Drugs** (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
     - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to Chapter 9 of your **Member Handbook**).

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

  - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to Chapter 9 of your **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 the drug.

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

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

Section B Sending us a request for payment

We do not allow UHC Dual Complete® (HMO D-SNP) providers to bill you for services or drugs. We pay our providers directly, and we protect you from any charges.

You should not pay the bill yourself. Send us the bill. You can also ask your care coordinator for help. Refer to Section A in this chapter or Chapter 9, Section F5 for more details.

For Medicare services, send us your bill and proof of any payment you made. 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 Member Services or your care coordinator for help.

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 a copy of the form on our website (**myuhc.com/communityplan**), or you can call Member Services and ask for the form.

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

UnitedHealthcare
P.O. Box 5270
Kingston, NY 12402-5270

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

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

Section C Coverage decisions

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

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

Chapter 3 of your **Member Handbook** explains the rules for getting your service covered.

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

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

Section D Appeals

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

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

- To make an appeal about getting paid back for a health care service, refer to Section F in Chapter 9.
- To make an appeal about getting paid back for a drug, refer to Section G in Chapter 9.

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 your **Member Handbook.**

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

You have a right to participate with practitioners in making decisions about your health care. We must support your right to make decisions about your care and a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

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

Table of Contents

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

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

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

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

You have a right to receive information about the **organization**, its services, its **practitioners** and providers and member rights and responsibilities.

You have a right to candid discussion of appropriate or medically necessary treatment options for their conditions, **regardless of cost or benefit coverage**.

You have a right to make recommendations regarding the organization's member rights and responsibilities policy.

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

- Medicare at **1-800-MEDICARE (1-800-633-4227)**. You can call 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- Civil Rights Coordinator, Minnesota Department of Human Services, **651-431-3040** or use your preferred relay service.
- Office of Civil Rights at **1-800-368-1019** or 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 your **Member Handbook**.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

  - Call Member Services or look in the **Provider and Pharmacy Directory** online at **myuhc.com/communityplan** to learn more about network providers and which doctors are accepting new patients.
- You have the right to use a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that is not 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 from network providers within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3 of your **Member Handbook**.
- If you need to talk to or see your Primary Care Provider after the office has closed for the day, call your Primary Care Provider's office. When the on-call physician returns your call he or she will advise you on how to proceed. If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

Chapter 9 of your **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 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 do not give your PHI to anyone who is 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 quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws.
- We, and the health providers who take care of you, have the right to look at information about your health care. When you enrolled in the Minnesota Health Care Program, you gave your consent for us to do this. We will keep this information private according to law.

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 are allowed to 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 whether the changes should be made.
- You have the right to know if and how we share your PHI with others.

If you have questions or concerns about the privacy of your PHI, call 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, 2024

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

- How we may use your HI.
- When we can share your HI with others.
- What rights you have 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 health insurance ID card.

Your Rights

You have the following rights for your medical information.

- **To ask us to limit** our use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others that help with your care or pay for your care. We may allow your dependents to ask for limits. **We 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 ID card.** Or you may contact the UnitedHealth Group Call Center at **1-866-842-4968**, or TTY/RTT **711.**
- **To Submit a Written Request.** Mail to:

  UnitedHealthcare Privacy Office
  MN017-E300
  PO Box 1459
  Minneapolis MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

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

[1]This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

FINANCIAL INFORMATION PRIVACY NOTICE

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

Effective January 1, 2024

We[2] protect your "personal financial information" ("FI"). FI is non-health information. FI identifies you and is generally not public.

Information We Collect

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

Sharing of FI

We 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 **1-866-842-4968,** or TTY/RTT **711.**

[2]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc. Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Health Care Solutions, Inc.; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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 at the number at the bottom of the page. This is a free service. Materials will be available in Spanish, Hmong, and Somali. We can also give you information in large print, braille, or audio.

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

- 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
  - The results of an external quality review study from the state
- 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
  - Whether we use a physician incentive plan that affects the use of referral services and details about the plan
- Covered services and drugs, including:
  - Services (refer to Chapters 3 and 4 of your **Member Handbook**) and drugs (refer to Chapters 5 and 6 of your **Member Handbook**) covered by our plan
  - Limits to your covered services and drugs
  - Rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to Chapter 9 of your **Member Handbook**), including asking us to:
  - Put in writing why something is not covered
  - Change a decision we made
  - Pay for a bill you got

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section E Inability of network providers to bill you directly

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

Section F Your right to leave our plan

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

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

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

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

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

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

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

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

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. The Senior LinkAge Line® is an organization that gives people information about Medicare or Medical Assistance, including resources for getting a form at **minnesotahelp.info/**. You can also contact Member Services to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.

- If you are being hospitalized and you have a signed an 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.

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 that a doctor or hospital did not follow the instructions in it, you can make a complaint with the Office of Health Facility Complaints at the Minnesota Department of Health at **651-201-4201**, or toll-free at **1-800-369-7994**.

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

Chapter 9 of your **Member Handbook** tells what you can do if you have any problems or concerns about your covered services or care. For example, you could 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 is **not** about discrimination for reasons listed in Chapter 11 of our **Member Handbook** — or you want more information about your rights, you can call:

- **Member Services**
- **The Senior LinkAge Line®** at **800-333-2433.** For details about the Senior LinkAge Line®, refer to Chapter 2 of your **Member Handbook**.
- **The Minnesota Ombudsperson for Public Managed Health Care Programs at 800-657-3729.** For more details about this program, refer to Chapter 2 of your **Member Handbook**.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at **medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.)

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, you can call Member Services.

- **Read this Member Handbook** to learn what is covered and what rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to Chapters 3 and 4 of your **Member Handbook**. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to Chapters 5 and 6 of our **Member Handbook**.
- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your Member ID Card 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.
  - Establish a relationship with a plan network primary care doctor before you become ill. This helps you and your primary care doctor understand your total health condition.
  - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Practice preventive health care. Have tests, exams, and shots recommended for you based on your age and gender.
  - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not 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 are responsible for these payments:

  - Medicare Part A and Medicare Part B premiums. For most of our members, Medical Assistance pays for your Medicare Part A premium and for your Medicare Part B premium.
  - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to Chapter 9 to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, it is important to tell us right away. Call Member Services.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be members of this plan. Chapter 1 of your **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 prescription drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and Medical Assistance your new address when you move. Refer to Chapter 2 of your **Member Handbook** for phone numbers for Medicare and Medical Assistance.
  - **If you move and stay in our service area, we still need to know**. We need to keep your membership record up to date and know how to contact you.
- **Call 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)

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 are having a problem with your care, you can call the Ombudsperson for Public Managed Health Care Programs at 651-431-2660 or 1-800-657-3729 or TTY MN Relay 711 or use your preferred relay service. This chapter explains the different options you have for different problems and complaints, but you can always call the Ombudsperson for Public Managed Health Care Programs to help guide you through your problem.

For more information about ombudsperson programs that can help you address your concerns, refer to Chapter 2 of your **Member Handbook**.

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? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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 have used 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"

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

Help from the Senior LinkAge Line®

You can call the Senior LinkAge Line®. Senior LinkAge Line® counselors can answer your questions and help you understand what to do about your problem. Senior LinkAge Line® is not connected with us or with any insurance company or health plan. Senior LinkAge Line® has trained counselors in every county, and services are free. The Senior LinkAge Line® phone number is **1-800-333-2433**.

Help and information from Medicare

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

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

Help and information from the Ombudsperson for Public Managed Health Care Programs

If you need help, you can always call the Ombudsperson for Public Managed Health Care Programs. The Ombudsperson for Public Managed Health Care Programs can answer your questions and help you understand what to do to handle your problem. Refer to Chapter 2 for more information on ombudsman programs.

The Ombudsperson for Public Managed Health Care Programs is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the Ombudsperson for Public Managed Health Care Programs is **651-431-2660** or **1-800-657-3729** or TTY MN Relay 711 or use your preferred relay service. The services are free.

Getting information from Livanta BFCC-QIO Program

You can call Livanta BFCC directly for help with problems. Here are two ways to get help from Livanta BFCC:

- Call **1-888-524-9900,** 9 a.m.–5 p.m. local time, Monday–Friday; 11 a.m.–3 p.m. local time, weekends and holidays. TTY: **1-888-985-8775**
- Visit the Livanta BFCC-QIO program website at **livantaqio.com**

Section C Understanding Medicare and Medical Assistance complaints and appeals in our plan

You have Medicare and Medical Assistance. Information in this chapter applies to all of your Medicare and Medical Assistance benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Medical Assistance processes.

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

Section D Problems with your benefits

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

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

Section E Coverage decisions and appeals

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

Section E1 Coverage decisions

What is a coverage decision?

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

We make a coverage decision whenever we decide what is covered for you and how much we pay. In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or Medical Assistance. If you disagree with this coverage decision, you can make an appeal.

Section E2 Appeals

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

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

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

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

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

Section E3 Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- Call the State Health Insurance Assistance Program (SHIP) for free help. The SHIP is an independent organization. It is not connected with this plan. In Minnesota the SHIP is called the Senior LinkAge Line®. The phone number is **1-800-333-2433** or TTY MN Relay **711** or use your preferred relay service. These calls are free.

- Call the Ombudsperson for Public Managed Health Care Programs for free help. The Ombudsperson for Public Managed Health Care Programs helps people enrolled in Medical Assistance with service or billing problems. The phone number is **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

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 **cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **myuhc.com/communityplan**. **You must give us a copy of the signed form.**

Section E4 Which section of this chapter can help you

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

Refer to the section that applies:

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

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

If you need other help or information, please call the Ombudsperson for Public Managed Health Care Programs at **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.

Section F Medical care

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

This section is about your benefits for medical care and services that are described in **Chapter 4** of your **Member Handbook**. We generally refer to "medical care coverage" or "medical care" in the rest of this section. The term "medical care" includes medical services and items as well as Medicare Part B prescription drugs which are drugs administered by your doctor or health care professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

Section F1 Using this section

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

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

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

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

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

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

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

4. You got and paid for medical care you thought were 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 us: **1-844-368-5888** TTY: **711** (or your preferred relay service)
- Faxing us: **1-888-950-1170**
- Writing: P.O. Box 30769, Salt Lake City, UT 84130-0769

Standard coverage decision

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

- Medical service or item within 14 calendar days after we get your request.
- Medicare Part B prescription drug within 72 hours after we get your request.

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

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

Fast coverage decision

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

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

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

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

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

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

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

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

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

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

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

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

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so,

or

- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

Section F3 Making a Level 1 Appeal

Ask for a standard appeal or a fast appeal in writing or by calling us at **1-844-368-5888**.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting **cms.gov/Medicare/CMS-Forms/CMSForms/downloads/cms1696.pdf** or on our website at **myuhc.com/communityplan**.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 60 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

The legal term for "fast appeal" is "**expedited reconsideration**."

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.

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

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

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.
  - If you do not appeal before these dates, then your service or item will not be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.
- **If 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 prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If you think we should **not** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights**:

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a Medical Assistance service or item, the letter tells you how to file a Level 2 Appeal yourself.

Section F4 Level 2 Appeal for services, items, and drugs (not Medicare Part D drugs)

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, Medical Assistance, 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 Medical Assistance 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 Medical Assistance** 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 by Medical Assistance, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity,"** sometimes called the **"IRE."**

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- If your request is for a Medicare Part B prescription drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO take extra time to make a decision if your request is for a Medicare Part B prescription drug. The IRO gives you their answer in writing and explains the reasons.
- **If the IRO says Yes to part or all of a request for a medical item or service**, we must:
  - Authorize the medical care coverage **within 72 hours**, **or**
  - Provide the service **within 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 prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests**, **or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says No to part or all of your appeal**, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal.

Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that is covered by both Medicare and Medical Assistance

A Level 2 Appeal for services that Medical Assistance usually covers is a Fair Hearing with the state. In Minnesota a Fair Hearing is called a Medicaid Fair Hearing with the State. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

You must ask for a State Appeal **within 120 days** of the date of the plan's appeal decision.

Mail, fax, or submit your written request to:

Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, MN 55164-0941

Fax: **651- 431-7523**

Online Appeal Form: **edocs.dhs.state.mn.us/lfserver/Public/DHS-0033-ENG**

A Human Services Judge from the State Appeals Office will hold the hearing. Your meeting will be by telephone unless you ask for a face-to-face meeting. During your hearing, tell the Judge why you disagree with the decision made by the plan. You can ask a friend, relative, advocate, provider, or lawyer to help you.

The process can take between 30 and 90 days. If your hearing is about an urgently needed service and you need an answer faster, tell the State Appeals Office when you file your hearing request. If your hearing is about a medical necessity denial, you may ask for an expert medical opinion from an outside reviewer. There is no cost to you.

If you need help at any point in the process, call the Ombudsperson for Public Managed Health Care Programs at **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item within 72 hours after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the IRO, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

Section F5 Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

We can't reimburse you directly for a Medicaid service or item. If you get a bill for Medicaid covered services or items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or item.

If you want us to reimburse you for a Medicare service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to Chapter 7 of your **Member Handbook**.

- If the service or item you paid for is covered and you followed all the rules, we will send the provider the payment for the service or item within 60 calendar days after we get your request. Your provider will then send the payment to you.
- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

If you do not agree with our decision not to pay, **you can make an appeal.** Follow the appeals process described in Section F3. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you cannot ask for a fast appeal.

If our answer is to your appeal is **No** and Medicare usually covers the service or item, we will send your case to the IRO. We will send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter

explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and Medical Assistance usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to Section F4 for more information.

Section G Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Medical Assistance may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time. For drugs covered only by Medicaid follow the process in Section E.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your **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 is not on our plan's Drug List or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions **and** how to make an appeal.

Use the chart below to help you:

Which of these situations are you in?

You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our Drug List and you think you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2** then refer to **Sections G3** and **G4**.	Skip ahead to **Section G4**.	Skip ahead to **Section G4**.	Skip ahead to **Section G5**.

Section G2 Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a "**formulary exception**."

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that is not on our Drug List.**
   - You cannot 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 your **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 plan approval before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - Quantity limits. For some drugs, we limit the amount of the drug you can have.

The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a "formulary exception."

Section G3 Important things to know about asking for an exception

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 would not cause more side effects or other health problems, we will generally do not approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to Section G5 for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

Section G4 Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling **1-844-368-5888**, 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.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to Chapter 7 of your **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 to give you a "fast coverage decision"

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.
- If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.
- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information 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. This means 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 you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

- If we do not meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** or 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 will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we send your request on 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 do not 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 **1-844-368-5888**, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 60 calendar 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 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 do not 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 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.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

Section H Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to Chapter 4 of your **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 are being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

Section H1 Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- Visit **cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischarge AppealNotices**.

Section H2 Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In Minnesota, the QIO is called Livanta. Call them at: **1-888-524-9900** (TTY: **1-888-985-8775**). Contact information is also on 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 do not call to appeal,** and you decide to stay in the hospital after your planned discharge date, you may pay costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the QIO about your appeal, appeal to our plan directly instead. Refer to **Section G4** for information about making an appeal to us.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Senior LinkAge Line® at **1-800-333-2433** or TTY MN Relay **711**.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

The legal term for "fast review" is "immediate review" or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY MN Relay **711** users should call **1-877-486-2048** or use your preferred relay service. Or you can find a sample notice online at **cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices**.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

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 **1-888-524-9900** (TTY: **1-888-985-8775**).

You must ask for this review **within 60 calendar days** after the day when the QIO said **No** to your Level 1 Appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says Yes to your appeal

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

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 H4 Making a Level 1 Alternate Appeal

The deadline for contacting the QIO for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

The legal term for "fast review" or "fast appeal" is "**expedited appeal**".

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say • **We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.**

to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

Section H5 Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the IRO within 24 hours of saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section I Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, and
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you before your services end.

When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**.

This section tells you how to ask for an appeal.

Section I1 Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The written notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice only shows that you got the information. Signing does not mean you agree with our decision.

Section I2 Making a Level 1 Appeal to continue your care

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.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **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 Senior LinkAge Line®, Minnesota's SHIP at **1-800-333-2433**, the call is free. Call the Minnesota Relay Service at **711**.
- **Contact the QIO.**
  - Refer to **Section H2** or refer to Chapter 2 of your **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.
- If you miss the deadline for contacting the QIO, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4**.

The legal term for the written notice is **"Notice of Medicare Non-Coverage"**. To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or get a copy online at **cms.gov/Medicare/Medicare-General-Information/BNI/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.
- 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 you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

If the QIO says Yes to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the QIO says No to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

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 **1-888-524-9900** (TTY: **1-888-985-8775**).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review only if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

Section I4 Making a Level 1 Alternate Appeal

As explained in **Section I2**, you must act quickly and contact the QIO to start your Level 1 Appeal. If you miss the deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review".

The legal term for "fast review" or "fast appeal" is "expedited appeal".

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.
- We agree to pay you back for the costs of care you got since the date when we said your coverage would end.
- If we say **No** to your fast appeal:
  - Our coverage for these services ends on the date we told you.
  - We will not pay any of the costs after this date.
  - You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
  - We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

Section I5 Making a Level 2 Alternate Appeal

- We send the information for your Level 2 Appeal to the the IRO within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don’t need to do anything.
- If you think we didn’t meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.
- The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to Section J for information about Level 3, 4, and 5 Appeals.

Section J Taking your appeal beyond Level 2

Section J1 Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says Yes to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide to **appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide to **accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide to **appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide to **accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

Section J2 Additional Medical Assistance appeals

You also have more appeal rights if your appeal is about services or items that might be covered by Medical Assistance. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process. If you disagree with the ruling from the State Appeal (Medicaid Fair Hearing with the state) process, you may appeal to the District Court in your county by calling the county clerk. You have 30 days to file an appeal with District Court.

If you need help at any stage of the process, you can call the Ombudsperson for Public Managed Health Care Programs at **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.

Section J3 Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

Section K How to make a complaint

Section K1 What kinds of problems should be complaints

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

Complaint	Example
Quality of your medical care	• You are unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone did not respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our plan.
Accessibility and language assistance	• You cannot physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office is not clean.

Complaint	Example
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 the Ombudsperson for Public Managed Health Care Programs at **651-431-2660** or **1-800-657-3729** or TTY MN Relay **711** or use your preferred relay service.

Section K2 Internal complaints

To make an internal complaint, call Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service. You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about. If you make a complaint after this 60 calendar day period, we will consider whether there is good cause for the late filing.

- If there is 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 will respond to your complaint in writing.
- We must receive your complaint within 60 calendar days of the event or incident you are complaining about. If something kept you from filing your complaint (you were sick, we provided incorrect information, etc.) let us know and we might be able to accept your complaint past 60 days. We will address your complaint as quickly as possible but no later than 30 days after receiving it. Sometimes we need additional information, or you may wish to provide additional information. If that occurs, we may take an additional 14 days to respond to your complaint. If the additional 14 days is taken, you will receive a letter letting you know.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

If your complaint is because we took 14 extra days to respond to your request for a coverage determination or appeal or because we decided you didn't need a fast coverage decision or a fast appeal, you can file a fast complaint. We will respond to you within 24 hours of receiving your complaint.

The legal term for "fast complaint" is "expedited grievance."

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

Section K3 External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: **medicare.gov/MedicareComplaintForm/home.aspx**. You do not need to file a complaint with UHC Dual Complete® (HMO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan is not addressing your problem, you can also call **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**. The call is free.

You can tell the Minnesota Department of Health about your complaint

Managed Care Systems
P.O. Box 64882
St. Paul, MN 55164-0882

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

You can also make a complaint at
health.state.mn.us/facilities/insurance/clearinghouse/complaints

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is **1-800-368-1019**. TTY users should call **1-800-537-7697**. You can visit **ocrportal.hhs.gov/ocr/portal/lobby.jsf** for more information.

You may also contact the local OCR office at:

Office of Civil Rights, Midwest Region
233 N. Michigan Ave., Suite 240
Chicago, IL 60601.

Call **1-800-368-1019**, fax **1-202-619-3818**, or email **ocrmail@hhs.gov**.

You may also have rights under the Americans with Disabilities Act (ADA).

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of your **Member Handbook**.

In Minnesota, the QIO is called Livanta. The phone number for Livanta is **1-888-524-9900** (TTY: **1-888-985-8775**).

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 will still be the Medicare and Medical Assistance programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your **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 Medical Assistance, you may be able to end your membership with our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You move out of our service area,
- Your eligibility for Medical Assistance or Extra Help has 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.
- Medical Assistance services in Section C2.

You can get more information about when 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)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- State Health Insurance Assistance Program (SHIP) at **1-800-333-2433**. In Minnesota, the Senior LinkAge Line®. TTY MN Relay users should call **711** or use your preferred relay service. These calls are free.

NOTE: If you are in a drug management program (DMP), you may not be able to change plans. Refer to Chapter 5 of your **Member Handbook** for information about drug management programs.

Section B How to end your membership in our plan

If you decide to end your membership, you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are 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)**, 24 hours a day, 7 days a week. TTY users (people who have difficulty with hearing or speaking) should call **1 877 486-2048**. When you call **1-800-MEDICARE**, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the table in Section C of this chapter.

Section C How to get your Medicare and Medical Assistance services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

Section C1 Ways to get your Medicare services

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	Here is what to do:
Another Medicare health plan	Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the Call the State Health Insurance Assistance Program (SHIP) at **1-800-333-2433** (TTY MN Relay users call **711** or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free. **OR** • Enroll in a new Medicare plan. You are automatically disenrolled from our Medicare plan when your new plan's coverage begins. If you choose to leave our plan, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county. You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions. If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services.

2. You can change to:	Here is what to do:
Original Medicare with a separate Medicare prescription drug plan	Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at **1-800-333-2433** (TTY MN Relay users call **711** or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free. • **OR** • Enroll in a new Medicare prescription drug plan. • You are automatically disenrolled from our plan when your Original Medicare coverage begins. If you choose to leave our plan, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county. You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions. If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services.

3. You can change to:	Here is what to do:
Original Medicare without a separate Medicare prescription drug plan **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the Senior LinkAge Line® at **1-800-333-2433** (TTY users call **711** or use your preferred relay service), Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local Senior LinkAge Line® office in your area, please visit **seniorlinkageline.com**.	Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at **1-800-333-2433** (TTY MN Relay users call **711** or use your preferred relay service). In Minnesota, the SHIP is called the Senior LinkAge Line®. These calls are free. You will automatically be disenrolled from our plan when your Original Medicare coverage begins. If you choose to leave our plan, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance (Medicaid) services if our MSC+ plan is offered in your county. You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. If our plan does not have an MSC+ plan in your county, you will be enrolled in the MSC+ plan that is available in your county. Contact your county financial worker if you have questions. If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance (Medicaid) will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance (Medicaid) services.

Section C2 Your Medical Assistance services

If you leave our plan, you will be automatically enrolled in our plan's Minnesota Senior Care Plus (MSC+) plan for your Medical Assistance services.

You can ask in writing to be enrolled in the MSC+ plan you were enrolled in before our plan's MSHO enrollment. Contact your county financial worker if you have questions.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

If you currently have a medical spenddown and you choose to leave our plan, your Medical Assistance will be provided fee-for-service. You will not be enrolled in another health plan for Medical Assistance services.

Section D Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in UHC Dual Complete® (HMO D-SNP) ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

Section E Other situations when your membership in our plan ends

These are cases when we must end your membership in the plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medical Assistance. Our plan is for people who qualify for both Medicare and Medical Assistance.
  - If you have Medicare and lose eligibility for Medical Assistance, our plan will continue to provide plan benefits for up to three months.
  - If after three months you have not regained Medical Assistance, coverage with our plan will end.
  - You will need to choose a new Medicare Part D plan in order to continue getting coverage for Medicare covered drugs.
  - If you need help, you can call the Senior LinkAge Line® at **1-800-333-2433** (TTY MN Relay users call **711** or use your preferred relay service). These calls are free.
- If you do not pay your medical spenddown, as applicable.
- If you move out of our service area.
- If you are away from our service area for more than six months.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services will notify us if you aren't 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 Medical Assistance (Medicaid) first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to arrange medical care for you and other members of our plan.
- If you let someone else use your Member ID Card 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

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

Section G Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for information about how to make a complaint.

? **If you have questions,** please call UHC Dual Complete® (HMO D-SNP) Member Services at **1-844-368-5888**, TTY **711**, or your preferred relay service, 8 a.m.–8 p.m., 7 days a week, October–March; Monday–Friday, April–September. The call is free. **For more information,** visit **myuhc.com/communityplan**.

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

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in your last chapter of your **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 are not included or explained in the **Member Handbook**. The main laws that apply are federal laws about the Medicare and Medical Assistance programs. State laws about the Medical Assistance program also apply. 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, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, sex, or sexual orientation. In addition, we don't treat you differently because of your marital status, medical condition, political beliefs, public assistance status, or receipt of health services.

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 **ocrportal.hhs.gov/ocr/portal/lobby.jsf** for more information.

You may also contact the local OCR office at:

- Office of Civil Rights, Midwest Region, at 233 N. Michigan Ave., Suite 240, Chicago, IL 60601.
- Call **1-800-368-1019**
- Fax **1-202-619-3818**
- Email **ocrmail@hhs.gov**
- Call your local the Office for Civil Rights, Midwest Region, at 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. You can also call the toll-free numbers above, fax **1-202-619-3818**, or email **ocrmail@hhs.gov**.
- Call the Minnesota Department of Human Rights (MDHR) at **1-800-657-3704**. TTY users can call **711** (or your preferred relay service). These calls are free. You can also visit **mn.gov/mdhr** for more information.
- 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 Medical Assistance 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 are injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and 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 Medical Assistance is the payer of last resort.

Section D Third party liability and subrogation

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

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

b. the recovery amount, minus the party's total procurement cost.

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

Section E Member liability

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

- Emergency services
- Urgently needed services
- Out-of-area and routine travel dialysis (must be received in a Medicare Certified Dialysis Facility within the United States)
- Post-stabilization services

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

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

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

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

1. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
2. Furnished in a setting appropriate to the patient's medical needs and condition;
3. Ordered and furnished by qualified personnel;
4. One that meets, but does not exceed, the patient's medical need; and
5. At least as beneficial as an existing and available medically appropriate alternative.

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

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

Section H Acts beyond our control

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

Section I Contracting medical providers and network hospitals are independent contractors

The relationships between us and our network providers and network hospitals are independent contractor relationships. None of the network providers or network hospitals or their physicians or employees are employees or agents of UnitedHealthcare Insurance Company or one of its affiliates. An agent would be anyone authorized to act on our behalf. Neither we nor any employee of UnitedHealthcare Insurance Company or one of its affiliates is an employee or agent of the network providers or network hospitals.

Section J Technology assessment

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

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

Section K Member statements

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

Section L Information upon request

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

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

Section M 2024 Enrollee Fraud & Abuse Communication

2024 Enrollee Fraud & Abuse Communication

How you can fight healthcare fraud

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

Here are some examples of potential Medicare fraud cases:

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

To report a potential case of fraud in a Medicare benefit program, call AARP® Medicare Advantage (HMO-POS) Customer Service at **1-800-643-4845** (TTY **711**), 24 hours a day, 7 days a week.

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

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

Section N Commitment

UnitedHealthcare's Clinical Services Staff and Physicians make decisions on the health care services you receive based on the appropriateness of care and service and existence of coverage. Clinical Staff and Physicians making these decisions: 1. Do not specifically receive reward for issuing non-coverage (denial) decisions; 2. Do not offer incentives to physicians or other health

care professionals to encourage inappropriate underutilization of care or services; and 3. Do not hire, promote, or terminate physicians or other individuals based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Section O Renew Active™ Terms and Conditions

Eligibility Requirements

Only members enrolled in a participating Medicare Plan insured by UnitedHealthcare Insurance Company ("UnitedHealthcare") and affiliates are eligible for the Renew Active program ("Program"), which includes, without limitation, access to standard fitness memberships at participating gyms/ fitness locations, online fitness and cognitive providers, digital communities, events, classes and discounts for meal delivery at no additional cost. By enrolling in the Program, you hereby accept and agree to be bound by these Terms and Conditions.

Enrollment Requirements

Membership and participation in the Program is voluntary. You must enroll in the Program according to the instructions provided on this website. Once enrolled, you must obtain your confirmation code and use it when signing up for any Program services. Provide your confirmation code when visiting a participating gym/fitness location to receive standard membership access at no additional cost, registering with an online fitness and/or cognitive providers, joining the Fitbit® Community for Renew Active, and to gain access to included discounts. Please note, that by using your confirmation code, you are electing to disclose that you are a Renew Active member with a participating UnitedHealthcare Medicare plan.

Program enrollment is on an individual basis and the Program's waived monthly membership rate for standard membership services at participating gyms and fitness locations is only applicable to individual memberships. You are responsible for any and all non-covered services and/or similar fee-based products and services offered by Program service providers (including, without limitation, gym/fitness centers, digital fitness offerings, digital cognitive providers, Fitbit, and other third party service offerings made available through the Program), including, without limitation, fees associated with personal training sessions, specialized classes, enhanced facility membership levels beyond the basic or standard membership level, and meal delivery. Fitness membership equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Access to gym and fitness location network may vary by location and plan.

Liability Waiver

Always seek the advice of a doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Certain services, discounts, classes, events, and online fitness offerings are provided by affiliates of UnitedHealthcare or other third parties not affiliated

with UnitedHealthcare. Participation in these third-party services are subject to your acceptance of their respective terms and policies. UnitedHealthcare and its respective subsidiaries are not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. UnitedHealthcare and its respective subsidiaries and affiliates do not endorse and are not responsible for the services or information provided by third parties, the content on any linked site, or for any injuries you may sustain while participating in any activities under the Program.

Other Requirements

You must verify that the individual gym/fitness location or service provider participates in the Program before enrolling. If a Program service provider you use, including a gym or fitness location, ceases to participate in the Program, your Program participation and waived monthly membership rate with such service provider through the Program will be discontinued until you join another service offered by a participating service provider. You will be responsible for paying the standard membership rates of the such service provider should you elect to continue to receive services from a service provider once that service provider ceases to participate in our Program. If you wish to cancel your membership with such service provider, you can opt to do so per the cancellation policy of the applicable service provider, including the applicable gym or fitness location. You should review your termination rights with a service provider when you initially elect to sign up with such service provider.

Data Requirements

Optum (the Program administrator) and/or your service provider will collect and electronically send and/or receive the minimum amount of your personal information required in order to facilitate the Program in accordance with the requirements of applicable laws, including privacy laws. Such required personal information includes, but is not limited to, program confirmation code, gym/fitness location/provider membership ID, activity year and month, and monthly visit count. By enrolling in the Program, you authorize Optum to request, and each service provider to provide, such personal information.

Chapter 12

Definitions of important words

Introduction

This chapter includes key terms used throughout your **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.

Actions: These include:

- Denial or limited authorization of type or level of service
- Reduction, suspension, or stopping of a service that was approved before
- Denial of all or part of a payment or service
- Not providing services in a reasonable amount of time
- Not acting within required time frames for grievances or appeals
- Denial of member's request to get services out of network for members living in a rural area with only one health plan

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Anesthesia: Drugs that make you fall asleep for an operation.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 of your **Member Handbook** explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Biological Product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs usually are made and sold by other drug companies.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized Care Plan."

Care team: Refer to "Interdisciplinary Care Team."

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 of your **Member Handbook** explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of 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.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. Chapter 9 of your **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 of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Direct access services: You can use any provider in our plan's network to get these services. You do not need a referral or prior authorization before getting services.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tiers: Groups of drugs on our **List of Covered Drugs** (Drug List). Generic, brand, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of 3 tiers. All drugs in the same tier level have the same copay. Refer to the Drug List for more information and examples.

Dual eligible individual: A person who qualifies for Medicare and Medicaid coverage.

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, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency is 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. The medical symptoms may be a serious injury or severe pain. This is also called an emergency medical condition.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Emergency medical transportation: Ambulance services, including ground and air transportation for an emergency medical condition.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded Services: Services that are not covered by this health plan.

External Quality Review Study: A study about how quality, timeliness and access of care are provided by UHC Dual Complete® (HMO D-SNP). This study is external and independent.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-income subsidy,” or “LIS.”

Family planning: Information, services and supplies to help a person decide about having children. These decisions include choosing to have a child, when to have a child or not to have a child.

Generic drug: A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is 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 and Community-Based Services (HCBS): Additional services that are provided to help you remain in your home.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care: Health care services for an illness or injury given in your home or in the community where normal life activities take the member.

Housing Stabilization Services: Services to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing. The purpose of these services is to support a person's transition into housing, increase long-term stability in housing in the community, and avoid future periods of homelessness or institutionalization.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital outpatient care: Care in a hospital that usually doesn't require an overnight stay. An overnight stay for observation could be outpatient care.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Services if you get any bills you don't understand.

Because we pay the entire cost for your services, you do **not** owe any cost-sharing. Providers should not bill you anything for these services.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.

Individualized Care Plan (ICP or Care Plan): A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you are formally admitted to the hospital for skilled medical services. If you were not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

List of Covered Drugs (Drug List): A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help".

Medical Assistance: This is the name of Minnesota's Medicaid program. Medical Assistance 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.

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. Medically necessary care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:

- be the services that other providers would usually order.
- help you get better or stay as well as you are.
- help stop your condition from getting worse.
- help prevent and find health problems.

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 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 of the services that are 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 prescription drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A distinct group of service or group provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to Chapter 5 of your **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 your **Member Handbook** for information about how to contact Member Services.

Minnesota Senior Care Plus (MSC+): A program in which the State contracts with health plans to cover and manage health care and Elderly Waiver services for Medical Assistance enrollees age 65 and older.

Minnesota Senior Health Options (MSHO): A program in which the State and CMS contract with health plans, including our plan, to provide services only for seniors eligible for both Medicare and Medical Assistance, including those covered by MSC+.

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 are licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and do not charge 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".

Notice of Action: A form or letter we send to you telling you about a decision on a claim, a service or any other action taken by our plan. This is also called a Denial, Termination, or Reduction (DTR).

Nursing home certifiable: A decision that you need a nursing home level of care. A screener uses a process called a Long Term Care Consultation to decide.

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in Chapters 2 and 9 of your **Member Handbook**.

Open access services: Federal and state law allow you to choose any physician, clinic, hospital, pharmacy, or family planning agency – even if not in our plan's network – to get these services.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". Chapter 9 of your **Member Handbook** explains coverage decisions.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3 of your **Member Handbook** explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Palliative care: Palliative care helps people with serious illnesses feel better. It prevents or treats symptoms and side effects of disease and treatment. Palliative care also treats emotional, social, practical, and spiritual problems that illnesses can bring up. Palliative care can be given at the same time as treatments meant to cure or treat the disease. Palliative care may be given when the illness is diagnosed, throughout treatment, during follow-up, and at the end of life.

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.

Physician services: Health care services provided or coordinated by a medical physician licensed under state law (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).

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

Prescription drugs: Drugs and medications that can be dispensed only with an order given by a properly authorized person.

Primary care clinic (PCC): The facility where you get most of the health care services you need, such as annual checkups, and helps coordinate your care. You may need to choose a primary care clinic when you enroll in our plan.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to Chapter 3 of your **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 your **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** (Drug List).

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Provider: The general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to Chapter 2 of your **Member Handbook** for information about the QIO.

Quality of care complaint: In this handbook, "quality of care complaint" means an expressed dissatisfaction about health care services resulting in potential or actual harm to a member. Complaints may be about access; provider and staff competence; clinical appropriateness of care; communications; behavior; facility and environmental considerations; and other factors that can have a negative effect on the quality of health care services.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in Chapters 3 and 4 of your **Member Handbook**.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to Chapter 4 of your **Member Handbook** to learn more about rehabilitation services.

Restricted Recipient Program: A program for members who got medical care and have not followed the rules or have misused services. If you are in this program, you must get health services from one designated primary care provider, one clinic, one hospital used by the primary care provider, and one pharmacy. UnitedHealthcare may designate other health care providers. You must do this for at least 24 months of eligibility for Minnesota Health Care Programs. Members in this program who fail to follow program rules will be required to continue in the program for an additional 36 months. The restricted recipient program does not apply to Medicare-covered 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 is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing care: Care or treatment that can only be given by licensed nurses.

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.

State Appeal: 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 hearing. If the hearing is decided in your favor, we must give you the service you asked for. You must ask for a hearing in writing. You may ask for a hearing if you disagree with any of the following:

- A denial, termination or reduction of service
- Enrollment in the Plan
- Denial in full or part of a claim or service
- Our failure to act within required timelines for prior authorization and appeals
- Any other action

State Medicaid agency: In Minnesota, this agency is the Minnesota Department of Human Services.

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you ask for.

Subrogation: Our right to collect money in your name from another person, group, or insurance company. We have this right when you get medical coverage under this plan for a service that is covered by another source or third party payer.

Substance use disorder: Using alcohol or drugs in a way that harms you.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

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PO Box 64976
St. Paul, MN 55164-0976

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