



Member Handbook 2025

UnitedHealthcare Connected® for MyCare Ohio (Medicare-Medicaid Plan)



Toll-free **1-877-542-9236**, TTY **711**

8 a.m.–8 p.m. local time, Monday–Friday
(voicemail available 24 hours a day, 7 days a week)



UHCCommunityPlan.com
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United
Healthcare®
Community Plan

+MyCareOhio
Connecting Medicare + Medicaid

UnitedHealthcare Connected® for MyCare Ohio (Medicare-Medicaid Plan)

Member Handbook

January 1, 2025–December 31, 2025

Your Health and Drug Coverage under UnitedHealthcare Connected® for MyCare Ohio (Medicare-Medicaid Plan)

Member Handbook Introduction

This handbook tells you about your coverage under UnitedHealthcare Connected® for MyCare Ohio through December 31, 2025. It explains health care services, behavioral health coverage, prescription drug coverage, and home and community-based waiver services (also called long-term services and supports). Long-term services and supports help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

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

This plan, UnitedHealthcare Connected® for MyCare Ohio, is offered by UnitedHealthcare Community Plan of Ohio, Inc. When this **Member Handbook** says “we,” “us,” or “our,” it means UnitedHealthcare Community Plan of Ohio, Inc. When it says “the plan” or “our plan,” it means UnitedHealthcare Connected® for MyCare Ohio.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). The call is free.

ATENCIÓN: Si habla español, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al **1-877-542-9236** (TTY **711**), de 8 a.m. a 8 p.m., hora local, de lunes a viernes (correo de voz disponible las 24 horas del día, los 7 días de la semana). La llamada es gratuita.

If you speak Somali, language assistance services, free of charge, are available to you. Call **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). The call is free.

Haddii aad ku hadasho Soomaali, adeegyada taageerada luqadda, oo bilaasha ah, ayaad heli kartaa. Wac **1-877-542-9236** (TTY **711**), 8 subaxnimo–8 habeenimo waqtiga deegaanka, Isniin–Jimce (fariin cod ah ayaa la heli karaa 24 saac maalintii/7 maalmood toddobaadkii). Wicitaanku waa bilaash.

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- UnitedHealthcare provides free services to help you communicate with us such as letters in other languages, Braille, large print, audio, or you can ask for an interpreter. Please contact our Customer Service number at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week), for additional information.

If you have any problems reading or understanding this document or any other UnitedHealthcare Connected® for MyCare Ohio information, please contact Member Services. We can explain the information or provide the information in your primary language. We may have the information printed in certain other languages or in other ways. If you are visually or hearing impaired, special help can be provided.

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

Disclaimers

UnitedHealthcare Connected® for MyCare Ohio (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

Coverage under UnitedHealthcare Connected® for MyCare Ohio (Medicare-Medicaid Plan) 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](https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families)** for more information on the individual shared responsibility requirement.

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

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter, just call us at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). Someone who speaks English or Spanish can help you. This is a free service.

Other hearing exam providers are available in the UnitedHealthcare network. The plan only covers hearing aids from a UnitedHealthcare Hearing network provider.

Food and OTC benefits have expiration timeframes. Call your plan or review your Evidence of Coverage (EOC) for more information.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **[UHCCommunityPlan.com](https://www.uhccommunityplan.com)**.

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Chapter 1

Getting started as a member

Introduction

This chapter includes information about UnitedHealthcare Connected® for MyCare Ohio, a health plan that covers all your Medicare and Medicaid services. It also tells you what to expect as a member and what other information you will get from UnitedHealthcare Connected® for MyCare Ohio. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

Section A **Welcome to UnitedHealthcare Connected® for MyCare Ohio**

UnitedHealthcare Connected® for MyCare Ohio, offered by UnitedHealthcare Community Plan of Ohio, Inc., is a Medicare-Medicaid Plan. A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care managers and care teams to help you manage all your providers and services. They all work together to provide the care you need.

UnitedHealthcare Connected® for MyCare Ohio was approved by the Ohio Department of Medicaid (ODM) and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the MyCare Ohio program.

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

Section B **Information about Medicare and Medicaid**

You have both Medicare and Medicaid. UnitedHealthcare Connected® for MyCare Ohio will make sure these programs work together to get you the care you need.

Section B1 **Medicare**

Medicare is the federal health insurance program for:

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

Section B2 **Medicaid**

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who qualifies,



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- 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 Ohio Department of Medicaid must approve UnitedHealthcare Connected® for MyCare Ohio each year. You can get Medicare and Medicaid services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the Ohio Department of Medicaid approve the plan.

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

Section C Advantages of this plan

You will now get all your covered Medicare and Medicaid services from UnitedHealthcare Connected® for MyCare Ohio, including prescription drugs. **You do not pay extra to join this health plan.**

UnitedHealthcare Connected® for MyCare Ohio will help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a care manager. This is a person who works with you, with UnitedHealthcare Connected® for MyCare Ohio, and with your care providers to make sure you get the care you need. They will be a member of your care team.
- You will be able to direct your own care with help from your care team and care manager.
- The care team and care manager will work with you to come up with a care plan specifically designed to meet your needs. The care team will be in charge of coordinating the services you need. This means, for example:
 - Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
 - Your care team will make sure your test results are shared with all your doctors and other providers.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section D UnitedHealthcare Connected® for MyCare Ohio's service area

UnitedHealthcare Connected® for MyCare Ohio is available only to people who live in our service area. To keep being a member of our plan, you must keep living in this service area.

Our service area includes these counties in Ohio: Columbiana, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull, and Wayne counties.

If you move, you must report the move to your County Department of Job and Family Services office. If you move to a new state, you will need to apply for Medicaid in the new state. Refer to Chapter 8 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 membership in our plan as long as:

- you live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it); **and**
- you have Medicare Parts A, B and D; **and**
- you have full Medicaid coverage; **and**
- you are a United States citizen or are lawfully present in the United States, **and**
- you are 18 years of age or older at time of enrollment.

Even if you meet the above criteria, you are not eligible to enroll in UnitedHealthcare Connected® for MyCare Ohio if you:

- have other third party creditable health care coverage; **or**
- have intellectual or other developmental disabilities and get services through a waiver or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFIID); **or**
- are enrolled in a Program of All-Inclusive Care for the Elderly (PACE).

Additionally, you have the choice to disenroll from UnitedHealthcare Connected® for MyCare Ohio if you are a member of a federally recognized Indian tribe.

If you believe that you meet any of the above criteria and should not be enrolled, please contact Member Services for assistance.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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

When you first join the plan, you will get a health care needs assessment within the first 15 to 75 days of your enrollment effective date depending on your health status. You will receive a phone call from your Health Plan Care Manager to schedule and do the comprehensive in-home assessment.

If UnitedHealthcare Connected® for MyCare Ohio is new for you, you can keep using the doctors you use now for at least 90 days after you enroll. Also, if you already had previous approval to get services, our plan will honor the approval until you get the services. This is called a “transition period.” The New Member Letter included with your **Member Handbook** has more information on the transition periods. If you are on the MyCare Ohio Waiver, your **Member Handbook Supplement** or “Waiver Handbook” also has more information on transition periods for waiver services.

After the transition period, you will need to use doctors and other providers in the UnitedHealthcare Connected® for MyCare Ohio network for most services. A network provider is a provider who works with the health plan. Refer to Chapter 3 for more information on getting care. Member Services can help you find a network provider.

If you are currently using a provider that is not a network provider or if you already have services approved and/or scheduled, it is important that you call Member Services right away so we can arrange the services and avoid any billing issues.

Section G Your care plan

Your care plan is the plan for what health services you will get and how you will get them.

After your health care needs assessment, your care team will meet with you to talk about what health services you need and want. Together, you and your care team will make your care plan.

Your care team will continuously work with you to update your care plan to address the health services you need and want.

Section H UnitedHealthcare Connected® for MyCare Ohio monthly plan premium

UnitedHealthcare Connected® for MyCare Ohio does not have a monthly plan premium.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section I The Member Handbook

This **Member Handbook** is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, refer to Chapter 9. You can also call Member Services at **1-877-542-9236** (TTY **711**), or Medicare at **1-800-MEDICARE (1-800-633-4227)**.

You can ask for a **Member Handbook** by calling Member Services at **1-877-542-9236** (TTY **711**). You can also refer to the **Member Handbook** at **UHCCommunityPlan.com** or download it from this website.

The contract is in effect for months in which you are enrolled in UnitedHealthcare Connected® for MyCare Ohio between January 1, 2025 and December 31, 2025.

Section J Other important information you will get from us



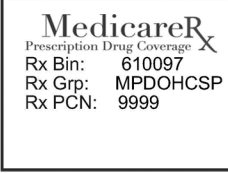
You will also get a UnitedHealthcare Connected® for MyCare Ohio Member ID Card, a New Member Letter with important information, information about how to access a **Provider and Pharmacy Directory** and **List of Covered Drugs**. Members enrolled in a home and community-based waiver will also get a supplement to their **Member Handbook** that gives information specific to waiver services. If you do not get these items, please call Member Services for assistance.

Section J1 Your UnitedHealthcare Connected® for MyCare Ohio Member ID card

Under the MyCare Ohio program, you will have one card for your Medicare and Medicaid services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions covered by the plan. Here's a sample card to show you what yours will look like:



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

 Health Plan (80840) **911-87726-04** 
Member ID: 000000413
Member:
NEW ENGLISH
MMIS: 999999941316 Payer ID: 87726
PCP Name:
DOUGLAS GETWELL
PCP Phone: (216)961-2090

Rx Bin: 610097
Rx Grp: MPDOHCSP
Rx PCN: 9999
UnitedHealthcare Connected for MyCare Ohio (Medicare-Medicaid Plan)
H2531 PBP# 001

Printed: 10/13/20
In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.
Website: MyUHC.com/CommunityPlan
Member Services: 1-877-542-9236 TTY 711
Behavioral Health Crisis: 1-877-542-9236 TTY 711
Care Management: 1-877-542-9236 TTY 711
24 Hour Nurse Advice: 1-800-542-8630 TTY 711
For Providers: 1-800-600-9007
Send claims to: PO Box 8207, Kingston, NY, 12402-8207
Eligibility Verification: 1-800-600-9007 Claim Inquiry: 1-800-600-9007
Pharmacy Claims: OptumRx, PO Box 650287, Dallas, TX 75265-0287
Pharmacy Help Desk: 1-877-889-6510

If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

As long as you are a member of our plan, this is the only card you need to get services. You will no longer get a monthly Medicaid card. You also do not need to use your red, white, and blue Medicare card. Keep your Medicare card in a safe place, in case you need it later. If you show your Medicare card instead of your UnitedHealthcare Connected® for MyCare Ohio Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7, Section A to find out what to do if you get a bill from a provider.

Section J2 New Member Letter

Please make sure to read the New Member Letter sent with your **Member Handbook** as it is a quick reference for some important information. For example, it has information on things such as when you may be able to get services from providers not in our network, previously approved services, transportation services, and who is eligible for MyCare Ohio enrollment.

Section J3 Provider and Pharmacy Directory

The **Provider and Pharmacy Directory** lists the providers and pharmacies in the UnitedHealthcare Connected® for MyCare Ohio network. While you are a member of our plan, you must use network providers and pharmacies to get covered services. There are some exceptions, including when you first join our plan (refer to Section E) and for certain services (refer to Chapter 3).

You can ask for a printed **Provider and Pharmacy Directory** (electronically or in hard copy form) at any time by calling Member Services at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voice mail available 24 hours a day, 7 days a week). Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

refer to the **Provider and Pharmacy Directory** at **UHCCommunityPlan.com**, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

Definition of network providers

- UnitedHealthcare Connected® for MyCare Ohio’s 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
 - Home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

For a full list of network providers, refer to the **Provider and Pharmacy Directory**.

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

Network providers should not bill you directly for services covered by the plan. For information about bills from network providers, refer to Chapter 7.

Definition of network pharmacies

- Network pharmacies are the pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the **Provider and Pharmacy Directory** to find the network pharmacy you want to use.
- Except in an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them. If it is not an emergency, you can ask us ahead of time to use a non-network pharmacy.

Section J4 List of Covered Drugs

The plan has a **List of Covered Drugs**. We call it the **Drug List** for short. It tells which prescription drugs are covered by UnitedHealthcare Connected® for MyCare Ohio.

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 for more information on these rules and restrictions.

Each year, we will 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, you can visit the plan’s website at **UHCCommunityPlan.com** or call Member Services at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week).



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section J5 Member Handbook Supplement or “Waiver Handbook”

This supplement provides additional information for members enrolled in a home and community based waiver. For example, it includes information on member rights and responsibilities, service plan development, care management, waiver service coordination, and reporting incidents.

Section J6 The Explanation of Benefits

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

The EOB tells you the total amount we, or others on your behalf, have paid for each of your Part D prescription drugs during the month and any copays you have made. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. Chapter 6 gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB is also available when you ask for one. To get a copy, contact Member Services.

Section K How to keep your membership record up to date

You can keep your membership record up-to-date by letting us know when your information changes.

The plan’s network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs are covered and any drug co-pay amounts for you.** Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage, such as from your employer, your spouse’s employer or your domestic partner’s employer, or workers’ compensation
- Admission to a nursing home or hospital
- Care in an out-of-area or out-of-network hospital or emergency room
- Changes in who your caregiver (or anyone responsible for you) is



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- You are part or become part of a clinical research study (NOTE: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so)
- If you have to use a provider for an injury or illness that may have been caused by another person or business. For example, if you are hurt in a car wreck, by a dog bite, or if you slip and fall in a store, then another person or business may have to pay for your medical expenses. When you call we will need to know the name of the person or business at fault as well as any insurance companies or attorneys that are involved.

If any information changes, please let us know by calling Member Services at **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week).

Section K1 Privacy of your personal health information (PHI)

The information in your membership record may include personal health information (PHI). Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, refer to Chapter 8.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **[UHCCommunityPlan.com](https://www.uhccommunityplan.com)**.

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 UnitedHealthcare Connected® for MyCare Ohio, the State of Ohio, Medicare, and your health care benefits. You can also use this chapter to get information about how to contact your care manager and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

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Section A How to contact UnitedHealthcare Connected® for MyCare Ohio Member Services

Method	Member services — Contact information
Call	<p>1-877-542-9236 This call is free.</p> <p>8 a.m.–8 p.m. local time, Monday–Friday. Voicemail is available 24 hours a day, 7 days a week.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>8 a.m.–8 p.m. local time, Monday–Friday. Voicemail is available 24 hours a day, 7 days a week.</p>
Write	<p>UnitedHealthcare Community Plan PO Box 6103 MS CA120-0360 Cypress, CA 90630</p> <p>If you are sending us an appeal or complaint, you can use the form in Chapter 9. You can also write a letter telling us about your question, problem, complaint, or appeal addressing it to UnitedHealthcare Complaint and Appeals Department at the above address.</p> <p>If you are sending us an appeal or complaint about your Part D prescription drugs, please write to us at:</p> <p>UnitedHealthcare Attn: Part D Standard Appeals PO Box 6103 MS CA120-0368 Cypress, CA 90630</p>
Website	UHCCommunityPlan.com

Section A1 When to contact Member Services

- Questions about the plan
- Questions about claims or billing from providers
- Member Identification (ID) Cards

Let us know if you didn't get your Member ID Card or you lost your Member ID Card.

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- Finding network providers

This includes questions about finding or changing your primary care provider (PCP).

- Getting long-term services and supports

In some cases, you can get help with daily health care and basic living needs. If it is determined necessary by the Ohio Department of Medicaid and UnitedHealthcare Connected® for MyCare Ohio, you may be able to get assisted living, homemaker, personal care, meals, adaptive equipment, emergency response, and other services.

- Understanding the information in your **Member Handbook**

- Recommendations for things you think we should change

- Other information about UnitedHealthcare Connected® for MyCare Ohio

You can ask for more information about our plan, including information regarding the structure and operation of UnitedHealthcare Connected® for MyCare Ohio and any physician incentive plans we operate.

- Coverage decisions about your health care and drugs

A coverage decision is a decision about:

- your benefits and covered services and drugs, **or**
- the amount we will pay for your health services and drugs.

Call us if you have questions about a coverage decision.

- To learn more about coverage decisions, refer to Chapter 9.

- Appeals about your health care and drugs

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.

- To learn more about making an appeal, refer to Chapter 9.

- Complaints about your health care and drugs

- You can make a complaint about us or any provider or pharmacy. You can also make a complaint to us or to the Quality Improvement Organization about the quality of the care you received (refer to Section E below).

- If your complaint is about a coverage decision about your health care or drugs, you can make an appeal (refer to the section above).



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- You can send a complaint about UnitedHealthcare Connected® for MyCare Ohio right to Medicare. You can use an online form at [medicare.gov/MedicareComplaintForm/home.aspx](https://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call **1-800-MEDICARE (1-800-633-4227)** to ask for help.
- You can send a complaint about UnitedHealthcare Connected® for MyCare Ohio directly to the Ohio Department of Medicaid. Call **1-800-324-8680**. This call is free. Refer to **Chapter 2** for other ways to contact Ohio Medicaid.
- You can send a complaint about UnitedHealthcare Connected® for MyCare Ohio to the MyCare Ohio Ombudsman. Call **1-800-282-1206**. This call is free.
- To learn more about making a complaint, refer to Chapter 9.
- Payment for health care or drugs you already paid for
 - For more on how to ask us to assist you with a service you paid for or to pay a bill you got, refer to Chapter 7.
 - 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 for more on appeals.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit [UHCCommunityPlan.com](https://www.UHCCommunityPlan.com).

Section B How to contact your Care Manager

UnitedHealthcare Connected® for MyCare Ohio (Medicare-Medicaid Plan) offers care management services to all members. The Care Manager is the director of your plan of care. The Care Manager assists with assessing your needs and health issues and works with your care team to define a plan of care. Our goal is to identify a care manager that best meets your needs; however, if you want to change your Care Manager you can call Member Services at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voice mail available 24 hours a day, 7 days a week).

Method	Care Manager – Contact information
Call	Your Care Manager directly or call Member Services at 1-877-542-9236 , 8 a.m.–8 p.m. local time, Monday–Friday and ask to be transferred to Care Management. After hours, please call 1-800-542-8630 . This call is free. The care manager call line is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	711 8 a.m.–5 p.m. Monday–Friday. After hours, please call 1-800-542-8630. This call is free. The care manager call line is available 24 hours a day, 7 days a week, 365 days a year.
Write	UnitedHealthcare Connected® for MyCare Ohio 5900 Parkwood Place Dublin, OH 43016

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section C How to contact the 24-Hour Behavioral Health Crisis Line

If you need mental health and/or substance use services, please call our member services line for assistance (help). You may also self-refer directly to a contracted Ohio Department of Mental Health and Addiction Services (OhioMHAS) certified provider for services.

Method	Behavioral Health Crisis Line — Contact information
Call	1-877-542-9236. This call is free. The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	711. This call is free. The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year.

Section C1 When to contact the Behavioral Health Crisis Line

- Questions about behavioral health services
- Questions about substance use disorder services

Section D How to contact the Quality Improvement Organization (QIO)

An organization called Livanta serves as Ohio’s QIO. 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
TTY	1-888-985-8775. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
Write	Ohio Livanta 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701
Website	livantaqio.com

? If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com**.

Section D1 When to contact Livanta

- Questions about your health care

You can make a complaint about the care you got if you:

- have a problem with the quality of care,
- think your hospital stay is ending too soon, **or**
- think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

Section E How to contact Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, 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 hearing or speaking problems. 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 homes, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities and hospices. It includes helpful websites and phone numbers. It also has booklets 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, print it out, and send it to you.

? **If you have questions or need to speak with your care manager,** please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com**.

Section F How to contact the Ohio Department of Medicaid

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources. Ohio Medicaid pays for Medicare premiums for certain people, and pays for Medicare deductibles, co-insurance and copays except for prescriptions. Medicaid covers long-term care services such as home and community-based “waiver” services and assisted living services and long-term nursing home care. It also covers dental and vision services.

You are enrolled in Medicare and in Medicaid. UnitedHealthcare Connected® for MyCare Ohio provides your Medicaid covered services through a provider agreement with the Ohio Department of Medicaid. If you have questions about the help you get from Medicaid, call the Ohio Medicaid Consumer Hotline.

Method	Ohio Department of Medicaid – Contact information
Call	1-800-324-8680. This call is free. The Ohio Medicaid Consumer Hotline is available Monday–Friday from 7 a.m.–8 p.m., and Saturday from 8 a.m.–5 p.m.
TTY	711. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
Write	Ohio Department of Medicaid Bureau of Managed Care 50 W. Town Street, Suite 400 Columbus, Ohio 43215
Email	bmhc@medicaid.ohio.gov
Website	medicaid.ohio.gov/provider/ManagedCare

You may also contact your local County Department of Job and Family Services if you have questions or need to submit changes to your address, income, or other insurance. Contact information is available online at: jfs.ohio.gov/County/County_Directory.pdf.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com**.

Section G How to contact the MyCare Ohio Ombudsman

The MyCare Ohio Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The MyCare Ohio Ombudsman also helps with concerns about any aspect of care. Help is available to resolve disputes with providers, protect rights, and file complaints or appeals with our plan.

The MyCare Ohio Ombudsman works together with the Office of the State Long-term Care Ombudsman, which advocates for consumers getting long-term services and supports. The MyCare Ohio Ombudsman is not connected with our plan or with any insurance company or health plan. Their services are free.

Method	MyCare Ohio Ombudsman – Contact information
Call	1-800-282-1206. This call is free. The MyCare Ohio Ombudsman is available Monday–Friday from 8 a.m.–5 p.m.
TTY	Ohio Relay Service: 1-800-750-0750. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
Write	Ohio Department of Aging Attn: MyCare Ohio Ombudsman 246 N High St., 1st Floor Columbus, OH 43215-2406
Website	aging.ohio.gov/care-and-living/get-help/get-an-advocate/long-term-care-ombudsman You can submit an online complaint at: aging.ohio.gov/contact/ .

? If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com**.

Section H The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it may help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January- December). This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in this payment option, regardless of income level, and plans with drug coverage must offer this payment option. Contact us at the phone number at the bottom of the page or visit **www.medicare.gov** to find out if this payment option is right for you.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Chapter 3

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

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with UnitedHealthcare Connected® for MyCare Ohio. It also tells you about your care manager, 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 when you are billed directly for services covered by our plan, and the rules for owning Durable medical equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at 1-877-542-9236 (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). For more information, visit UHCCommunityPlan.com.

Section A Information about “services,” “covered services,” “providers,” “network providers,” and “network pharmacies”

Services are health care, long-term services and supports, supplies, behavioral health, 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 and long-term services and supports are listed in the Benefits Chart in Chapter 4.

Providers are doctors, nurses, and other people who deliver services and care. The term providers also includes hospitals, home health agencies, clinics, and other places that deliver health care services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you pay nothing for covered services. The only exception is if you have a patient liability for nursing facility or waiver services. Refer to Chapter 4 for more information.

Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Network pharmacies bill us directly for prescriptions you get. When you use a network pharmacy, you only pay the co-pay amount for your prescription drugs. Refer to Chapter 6 for more information.

Section B Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan

UnitedHealthcare Connected® for MyCare Ohio covers health care services covered by Medicare and Medicaid. This includes behavioral health and long-term services and supports.

UnitedHealthcare Connected® for MyCare Ohio will generally pay for the health care and services you get if you follow plan rules. To be covered by our plan:

- The care you get must be a **plan benefit**. Refer to Chapter 4 for information regarding covered benefits, including the plan's Benefits Chart.
- The care must be **medically necessary**. Medically necessary means you need services, supplies, or drugs to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, equipment, or drugs meet accepted standards of medical practice.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- The care you get must be prior authorized by UnitedHealthcare Connected® for MyCare Ohio when required. For some services, your provider must submit information to UnitedHealthcare Connected® for MyCare Ohio and ask for approval for you to get the service. This is called prior authorization (PA). Refer to the chart in Chapter 4 for more information.
- You must choose a network provider to be your **primary care provider (PCP)** to manage your medical care. Although you do not need approval (called a referral) from your PCP to use other providers, it is still important to contact your PCP before you use a specialist or after you have an urgent or emergency department visit. This allows your PCP to manage your care for the best outcomes.
 - To learn more about choosing a PCP, refer to **Section D**.
- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the plan (an out-of-network provider). Here are some cases when this rule does not apply:
 - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out what emergency or urgently needed care means, refer to **Section H**.
 - If you need care that our plan covers and our network providers cannot give it to you, you can get this care from an out-of-network provider. Please contact your Care Manager about this before you get this care. A PA will be required. In this situation, we will cover the care as if you got it from a network provider. To learn about getting approval to use an out-of-network provider, refer to **Section D**.
 - The plan covers services you got at out-of-network Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and qualified family planning providers listed in the **Provider and Pharmacy Directory**.
 - If you are getting assisted living waiver services or long-term nursing facility services from an out-of-network provider on and before the day you become a member, you can continue to get the services from that out-of-network provider.
 - The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility.
 - If you are new to our plan, you may be able to continue to use your current out-of-network providers for a period of time after you enroll. This is called a "transition period". For more information, refer to Chapter 1 of this handbook and your New Member Letter.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section C Information about your care team and care manager

Your care team includes a personal Care Manager and your PCP as part of the core team.

Our goal is to use a person-centered approach to assess and develop a plan of care with you, your family and caregivers. Together your Care Team develops a plan to help meet your needs.

We will get to know your needs by reviewing your current health, mental health, and substance use information. You will receive a welcome call from the Integrated Care Team to verify receipt of Welcome materials and identify any immediate health care, mental health, or substance use care needs.

We will identify what you need to help maintain your health and mental health, and feel as good as possible, including: what types of medications do you need today or in the future? Do you have any medical, mental health or substance use needs that have been planned or recommended by your doctor, mental health or substance use providers?

Everything revolves around your health, mental health, and substance use care needs.

How it works:

- We'll go over your health, mental health, and substance use history and make sure we have everything you need.
- We'll create a customized plan of care based on your individual needs.
- We'll coordinate with family members, caregivers, mental health, substance use, and health care providers.
- We'll help you to make sure you get the services you may need.

Section C1 What care management is

Your Care Manager helps you manage all of your providers and services and helps link you to local resources. They work with your care team to make sure you get the care you need.

UnitedHealthcare Connected® for MyCare Ohio (Medicare-Medicaid Plan) offers care management services to all members. When you first join our plan, you will receive a health care needs assessment within the first 15 to 75 days of your enrollment effective date depending on your health status. Your Care Manager or your Community Health Worker will call you to set this up. Your Community Health Worker will welcome new members to our plan, perform Health Risk Assessments and coordinate members' identified needs with the care management department.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **[UHCCommunityPlan.com](https://www.uhccommunityplan.com)**.

The Care Manager is the director of your plan of care. Using a computerized assessment tool, your Care Manager documents information that assists your overall care team in assessing your needs and health, mental health, and substance use issues. Your Care Manager also works with your care team to define a plan of care to help meet your needs.

The Care Manager uses the appropriate level of UnitedHealthcare Connected® for MyCare Ohio (Medicare-Medicaid Plan) licensed professionals and health workers to support this effort. They can be a Licensed Social Worker (LSW or LISW), Licensed Counselor (LPC or LPCC), Registered Nurse (RN), Licensed Practical Nurse (LPN), aging/disability specialist, behavioral health specialist, peer support specialist and Community Health Worker. The Care Manager is the accountable point of contact in directing your plan of care.

Section C2 How you can contact your care manager

If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). These calls are free.

Section C3 How you will interact with your care manager and care team

We will determine the care coordination team outreach based on your health, mental health, substance use needs, service eligibility, cultural and language needs, family and/or community supports and state program design. Our goal is to identify a care coordinator with the needed clinical specialty and assign them to best meet your needs; however, if you want to change your Care Manager you can call Care Management at **1-877-542-9236 (TTY 711)**.

Since your health, mental health, and substance use care needs may change from time to time, your Care Manager will be responsible for sharing the changes with the care team that assists you. Of course, your input and permission are always considered when sharing your plan of care. In order to coordinate care for you, your Care Team needs to know your most up-to-date plan of care, which may include tests, procedures, and specialist visits. The Care Manager will track and follow your medications, as these can also change from time to time. It is important that you and your Care Team understand your medication changes.

Our goal is to serve our members through a comprehensive and integrated care management program that supports the individuals' choice to live in the least restrictive environment, maintain independence, and help overcome barriers.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section C4 How you can change your care manager

If you would like to change your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). These calls are free.

Section D Care from primary care providers, specialists, other network providers, and out-of-network providers

Section D1 Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

Definition of “PCP” and what a PCP does

- A Primary Care Provider (PCP) is a licensed network physician, physician group practice, advance practice nurse, certified nurse practitioner, physician assistant, or advance practice nurse group who is selected by you to provide or coordinate your covered services.
- PCPs are physicians specializing in family/general practice, internal medicine, pediatrics, geriatrics and obstetrics/gynecology (OB/GYN). Under certain circumstances, members may go to other specialists who may be considered as a PCP. An example may be a cardiologist; and you will work with your Care Manager to coordinate services. Sometimes there may be a reason that a specialist may need to be your PCP. A specialist serves as a PCP for members with very complex health care needs. If you and/or your specialist believe that they should be your PCP, you should talk to your Care Manager about this.
- 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. The provider giving you the care is the person responsible for getting the okay (PA) for the things listed in the Benefit Chart in Chapter 4 as needing one. You will be responsible for developing and maintaining a relationship with your PCP.
- A community-based clinic such as a family practice clinic, Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC), may serve as your PCP. If you choose a clinic, FQHC or RHC, the name of that clinic will appear on your Member ID card. In this instance, you may be seen by any provider within the clinic, FQHC or RHC. Some Primary Care Provider sites may have medical residents, nurse practitioners and provider assistants who will provide care to you under

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

the supervision of your PCP. While you may receive your care in a hospital clinic or community health center (RHC/FQHC/Family Planning clinic), we will try to assign you to a physician at that clinic who will be the primary person responsible for your care.

Your choice of PCP

Upon enrollment, the Plan will help you choose a PCP. Member Services can assist you in the selection of a new PCP whenever necessary. If there is a particular specialist or hospital that you want to use, check first to see if they are in our network of providers.

For a copy of the most recent **Provider and Pharmacy Network Directory**, or for help in selecting a PCP, call Member Services or use our Provider look-up tool online at **UHCCommunityPlan.com**.

Option to change your PCP

You may change your PCP for any reason. You can change your PCP to another network PCP monthly. Also, it's possible that your PCP might leave our plan's network. If your provider leaves our network, we can help you find a new PCP.

If you want to change your PCP, call Member Services. PCP changes within the first month of membership will be effective the date of the request. If you request a PCP change after your first month of membership, the change will be effective on the first day of the next month. You will receive a new membership ID card that shows your new PCP name and phone number.

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. Here are a few examples:

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

When you and your PCP (Primary Care Provider) agree you need to use another doctor (specialist), they will refer you to that doctor. This means the doctor recommends another doctor for you to use. **You do not need a referral from your PCP to use a network specialist or mental health/substance use provider.** Although you do not need a referral from your PCP to use a network specialist, your PCP can recommend an appropriate network specialist for your medical, mental health, or substance use issues, answer questions you have regarding a network specialist's plan of care and provide follow-up health care as needed. For coordination of care, we recommend you notify your PCP and your Care Team when you use a network specialist. Your Care Team can help you get a PA if you need one.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

A PA means that you must get approval from the plan before getting a specific service or drug. We will make the PA decision and let you and your provider know what we've decided. The provider who is going to do the service for you is responsible for getting the PA. Please look at the Benefits Chart in Chapter 4 for information about which services require PA.

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

Learn more about network doctors.

You can learn information about network doctors at **UHCCommunityPlan.com** or by calling Member Services. We can tell you the following information:

- Name, address, telephone numbers.
- Professional qualifications.
- Specialty.
- Medical school attended.
- Residency completion.
- Board Certification status.
- Languages spoken.

Section D3 What to do when a provider leaves our plan

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

- Even though our network of providers may 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 will help you select a new qualified in-network provider to continue managing your health care needs.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we will 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 cannot 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 believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to make a complaint. Refer to Chapter 9 for information about making an appeal.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. We can be reached at the phone number listed in Chapter 2.

Section D4 How to get care from out-of-network providers

We will only pay for care you get from out-of-network providers if you have followed the rules in the **“You must get your care from network providers”** Section C in this Chapter. The provider is responsible for calling us and getting any prior authorization (PA) necessary. Please review Chapter 4 for more information on what services need a PA.

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

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

Section E How to get long-term services and supports (LTSS)

Nursing Facility/Long-term Care Services and Supports are covered by UnitedHealthcare Connected® for MyCare Ohio (Medicare-Medicaid Plan). A range of home and community-based services and supports are available to you to enable you to live as independently as possible. The



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

most appropriate setting for receiving long-term care services is considered by you, your PCP and your Care team to help ensure we meet your needs and that you receive services whether it is in the community, an assisted living facility, or a nursing facility.

The Office of the State Long-Term Care Ombudsman helps people get information about long-term care services in nursing homes and in your home or community, and resolve problems between providers and members or their families. They can help you file a complaint or an appeal with our plan in regard to your nursing home or long term care services and supports. You can call **1-800-282-1206** Monday–Friday 8 a.m.–5 p.m. Calls to this number are free. You can submit an online complaint at: **aging.ohio.gov/contact/** or you can send a letter to:

Ohio Department of Aging: LTC Ombudsman
246 N High St., 1st Floor
Columbus, OH 43215-2406

Section F How to get behavioral health services

If you need mental health and/or substance use (behavioral health) services, please call Member Services. You can also find additional UnitedHealthcare Connected® MyCare Ohio providers on our website at **UHCommunityPlan.com** and in our **Provider and Pharmacy Network Directory**.

You may utilize an Ohio Department of Mental Health and Addiction (OhioMHAS) certified provider. If you decide to use an OhioMHAS certified provider, you do not need a prior authorization (PA) for outpatient therapy as long as the provider is contracted. The provider must get a prior authorization PA from UnitedHealthcare Connected® for MyCare Ohio before you get other services from these providers. These services can include intensive outpatient, partial hospitalization, community psychiatric support treatment, psychological testing, ambulatory detoxification and methadone maintenance.

Services from non-OhioMHAS that require an authorization include: inpatient mental health, inpatient detoxification, outpatient ECT, intensive outpatient, partial hospitalization, psychological testing, and ambulatory detoxification.

Section G How to get transportation services

If you need a ride to your PCP or other medical provider, we may be able to help if you must travel 30 miles or more from your home to receive covered health care services, UnitedHealthcare Connected® for MyCare Ohio will provide transportation to and from the provider's office.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

Section G1 How to get transportation services

- Please contact Member Services at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week).
- You must call at least 48 hours in advance of your appointment for assistance.
- Reservations are required and you must have a scheduled appointment (except in the case of urgent/emergent care).
- Coverage includes trips by ambulance, ambulette, and trips over 30 miles when there is not a closer provider available that can provide the same service. Waiver transportation is determined by the member's waiver service plan.

In addition to the transportation assistance that UnitedHealthcare Connected® for MyCare Ohio provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services.

Section H How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

Section H1 Care when you have a medical emergency

Definition of 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, if pregnant, to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when:
 - there is not enough time to safely transfer you to another hospital before delivery.
 - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital, or other appropriate setting. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP or UnitedHealthcare Connected® for MyCare Ohio. 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 from any provider with an appropriate state license.
- Be sure to tell the provider that you are a UnitedHealthcare Connected® for MyCare Ohio member. Show the provider your UnitedHealthcare Connected® for MyCare Ohio Member ID Card.
- **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Also, if the hospital has you stay, please make sure UnitedHealthcare Connected® for MyCare Ohio is called within 48 hours using the phone number on the back of your ID card. However, you will not have to pay for emergency services because of a delay in telling us.

Covered services in a medical emergency

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, refer to the Benefits Chart in Chapter 4.

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. 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. If the provider that is treating you for an emergency takes care of the emergency but thinks you need other medical care to treat the problem that caused the emergency, the provider must call us as soon as possible.

What to do if you have a behavioral health emergency

If you need mental health and/or substance use services, please call our member services line for assistance (help). You may also self-refer directly to a contracted Ohio Department of Mental Health and Addiction Services (OhioMHAS) certified provider for services. Please call **1-877-542-9236**. This call is free. The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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 might go in for emergency care and have the doctor say it wasn't really an emergency. As long as you reasonably thought your health or the health of your unborn child was in serious danger, we will cover your care.

However, after the doctor says it was *not* 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 H2 Urgently needed care

Definition of urgently needed care

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

Urgently needed care when you are in the plan's service area

In most situations, 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.

However, if it is not possible or reasonable to get to a network provider, given your time, place, or circumstances, we will cover urgently needed care you get from an out-of-network provider.

You can find a list of the contracted Urgent Care Centers in the Provider and Pharmacy Directory or call Member Services at **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week).

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

When you are outside the plan's service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

Our plan does not cover urgently needed care or any other care that you get outside the United States or its territories.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section H3 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 UnitedHealthcare Connected® for MyCare Ohio.

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

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

Section I What to do if you are billed directly for services covered by our plan

Providers should bill us for providing you covered services. You should not get a provider bill for services covered by the plan. If a provider sends you a bill for a covered service instead of sending it to the plan, you can ask us to pay the bill. Call Member Services as soon as possible to give us the information on the bill.

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

If a provider or pharmacy wants you to pay for covered services, you have already paid for covered services, or if you got a bill for covered services, **refer to Chapter 7 to learn what to do.**

Section I1 What to do if services are not covered by our plan

UnitedHealthcare Connected® for MyCare Ohio covers all services:

- that are medically necessary, **and**
- that are listed in the plan's Benefits Chart (refer to Chapter 4), **and**
- that you get by following plan rules.

If you get services that aren't covered by our plan, **you may have to pay the full cost yourself.**

If you want to know if we will 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.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit UHCCommunityPlan.com.

Chapter 9 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you do not have PA from UnitedHealthcare Connected® for MyCare Ohio to go over the limit, you may have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are, how close you are to reaching them, and what your provider must do to ask to exceed the limit if they think it is medically necessary.

Section J Coverage of health care services covered when you are in a clinical research study

Section J1 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 will contact you. That person will tell you about the study and find out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate 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 from our plan 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 requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies and may be subject to prior authorization and other plan rules.

We encourage you to tell us before you start participating in a clinical research study.

If you plan to be in a clinical research study, you or your Care Manager should contact Member Services to let us know you will be in a clinical trial.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section J2 Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay 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 are covered for most items and services 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 will have to pay any costs for being in the study. Ohio Medicaid does not cover clinical research studies.

Section J3 Learning more about clinical research studies

You can learn more about joining a clinical research study by reading “Medicare and Clinical Research Studies” on the Medicare website ([medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf](https://www.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 K How your health care services are covered when you get care in a religious non-medical health care institution

Section K1 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 will 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 K2 Getting 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-expected.”

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- “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, the following applies:
 - 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 our plan before you are admitted to the facility or your stay will not be covered.
 - Inpatient Hospital coverage limits are the same as what is in the Benefits Chart in Chapter 4.

Section L Durable medical equipment (DME)

Section L1 DME as a member of our plan

DME includes certain 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 will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of UnitedHealthcare Connected® for MyCare Ohio, you usually will not own DME, no matter how long you rent it. In certain limited situations, we will 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.

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section L2 **DME ownership when you switch to Original Medicare or Medicare Advantage**

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage 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 Medicare Advantage Plans in Chapter 11. You can also find more information about them in the **Medicare & You 2025** handbook. If you don't have a copy of this booklet, you can get it at the Medicare website ([medicare.gov](https://www.medicare.gov)) 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 Medicare Advantage 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 a Medicare Advantage plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage 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 Medicare Advantage plan to own the DME item.
- There are no exceptions to this case when you return to Original Medicare or Medicare Advantage plan.

Section L3 **Oxygen equipment benefits as a member of our plan**

If you qualify for oxygen equipment covered by Medicare and you are 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 or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **[UHCCommunityPlan.com](https://www.UHCCommunityPlan.com)**.

Section L4 **Oxygen equipment when you switch to Original Medicare or Medicare Advantage**

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will 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 the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide 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 will 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 a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

Chapter 4

Benefits Chart

Introduction

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

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section A Your covered services

This chapter tells you what services UnitedHealthcare Connected® for MyCare Ohio covers, how to access services, and if there are any limits on services. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5 and information about what you pay for drugs is in Chapter 6.

Because you get assistance from Medicaid, you generally pay nothing for the covered services explained in this chapter as long as you follow the plan's rules. Refer to Chapter 3 for details about the plan's rules. However, you may be responsible for paying a "patient liability" for nursing facility or waiver services that are covered through your Medicaid benefit. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.

If you need help understanding what services are covered or how to access services, please call Member Services at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voice mail available 24 hours a day, 7 days a week) or your Care Manager at **1-877-542-9236**, 24 hours a day, 7 days a week.

Section A1 During public health emergencies

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 UnitedHealthcare Connected® for MyCare Ohio. During a declared disaster, some telehealth services will be available for patients under the UnitedHealthcare Connected® for MyCare Ohio per guidance from our local and federal regulators. The duration of coverage of these services will follow state and federal guidance. Please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week) for more information.

UnitedHealthcare Connected® for MyCare Ohio will cover all COVID-19 testing, treatment, and vaccinations without copays.

COVID-19 testing

You can find COVID-19 testing locations online at coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/other-resources/testing-ch-centers.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit UHCCommunityPlan.com.

COVID-19 vaccinations

The Ohio Department of Health (ODH) has a search tool you can use to find a vaccine provider. You can search the directory by county and ZIP code. It displays providers currently getting shipments of COVID-19 vaccines. You can get information and vaccination locations at **vaccine.coronavirus.ohio.gov/** or by calling ODH toll-free at **833-427-5634**.

UnitedHealthcare Connected® for MyCare Ohio can help you find a testing or vaccination location in your community. They also can help with scheduling and transportation to your appointment. Use the information at the bottom of the page to contact UnitedHealthcare Connected® for MyCare Ohio Member Services or the Nurse Advice Hotline at **1-877-542-9236** (TTY **711**).

ODH gives regular updates on vaccination eligibility phases at **coronavirus.ohio.gov/wps/portal/gov/covid-19/covid-19-vaccination-program**.

Section B Rules against providers charging you for services

Except as indicated above, we do not allow UnitedHealthcare Connected® for MyCare Ohio 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 covered service.

You should never get a bill from a provider for a covered service. If you do, refer to Chapter 7 or call Member Services.

Section C Our plan's Benefits Chart

The following Benefits Chart in Section D is a general list of services the plan covers. It lists preventive services first and then categories of other services in alphabetical order. It also explains the covered services, how to access the services, and if there are any limits or restrictions on the services. If you can't find the service you are looking for, have questions, or need additional information on covered services and how to access services, contact Member Services or your Care Manager.

We will cover the services listed in the Benefits Chart only when the following rules are met:

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and the Ohio Department of Medicaid.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- The services (including medical care, services, supplies, equipment, and drugs) must be a plan benefit and must be medically necessary. Medically necessary means you need the services 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 home. It also means the services, supplies, or drugs meet accepted standards of medical practice.
 - If UnitedHealthcare Connected® for MyCare Ohio makes a decision that a service is not medically necessary or not covered, you or someone authorized to act on your behalf may file an appeal. For more information about appeals, refer to Chapter 9.
- For new enrollees, the plan must provide a minimum 90-day transition period, during which time the new Medicare Advantage plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization (PA). Also, some of the services listed in the Benefits Chart are covered only if your doctor or other network provider writes an order or a prescription for you to get the service.
 - If you are not sure whether a service requires PA, contact your Care Manager, Member Services, or visit our website at **UHCCommunityPlan.com**.
 - We mark covered services in the Benefits Chart that may need PA with an obelisk (†).

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above. The only exception is if you have a patient liability for nursing facility services or waiver services as determined by the County Department of Job and Family Services.

New technology assessment.

Some medical practices and treatments are not yet proven to be effective. New practices, treatments, tests and technologies are reviewed nationally by UnitedHealthcare Community Plan to make decisions about new medical practices and treatments and what conditions they can be used for. This information is reviewed by a committee of UnitedHealthcare Community Plan doctors, nurses, pharmacists and guest experts who make the final decision about coverage. If you would like more information about how we make decisions about new medical practices and treatments, call us at **1-877-542-9236**, TTY **711**.



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Section D The Benefits Chart

Section D1 Preventive visits

Services covered by our plan	Limitations and exceptions
<p>Annual checkup</p> <p>This is a visit to make or update a prevention plan based on your current risk factors. Annual checkups are covered once every 12 months.</p> <p>Note: You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first.</p>	
<p>“Welcome to Medicare” visit</p> <p>If you have been in Medicare Part B for 12 months or less, you can get a one-time “Welcome to Medicare” preventive visit. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. This visit includes:</p> <ul style="list-style-type: none"> • 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. 	
<p>Well child check-up (also known as Healthchek)</p> <p>Healthchek is Ohio’s early and periodic screening, diagnostic, and treatment (EPSDT) benefit for everyone in Medicaid from birth to under 21 years of age. Healthchek covers medical, vision, dental, hearing, nutritional, development, and mental health exams. It also includes immunizations, health education, and laboratory tests.</p>	†



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Section D2 Preventive services and screenings

Services covered by our plan	Limitations and exceptions
<p>Abdominal aortic aneurysm screening</p> <p>The plan covers a one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	
<p>Alcohol misuse screening and counseling</p> <p>The plan covers alcohol misuse screenings for adults. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions with a qualified primary care provider or practitioner.</p>	
<p>Bone mass measurements</p> <p>The plan covers 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. The plan will also cover a doctor looking at and commenting on the results.</p>	
<p>Breast cancer screening</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Women under the age of 35 who are at high risk for developing breast cancer may also be eligible for mammograms • Annual clinical breast exams 	

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Services covered by our plan	Limitations and exceptions
<p>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</p> <p>The plan covers visits with your primary care provider to help lower your risk for heart disease. During this visit, your provider may:</p> <ul style="list-style-type: none"> • discuss aspirin use, • check your blood pressure, or • give you tips to make sure you are eating well. 	
<p>Cardiovascular (heart) disease testing</p> <p>The plan covers blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease.</p>	
<p>Cervical and vaginal cancer screening</p> <p>The plan covers pap tests and pelvic exams annually for all women.</p>	

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Services covered by our plan	Limitations and exceptions
<p>Colorectal cancer screening</p> <p>The plan will pay for the following services:</p> <ul style="list-style-type: none"> • 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. <p>Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered noninvasive stool-based colorectal cancer screening test returns a positive result.</p>	

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Services covered by our plan	Limitations and exceptions
<p>Counseling and interventions to stop smoking or tobacco use</p> <p>The plan covers tobacco cessation counseling and intervention. As a preventive service, the plan covers counseling on attempts to quit by your PCP as well as the Tobacco Quitline. You can call 1-800-QUITNOW or 1-800-784-8669 at any time.</p>	<p>†</p>
<p>Dental services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • comprehensive oral exam (one per provider-patient relationship) • periodic oral exam once every 180 days for members under 21 years of age, and once every 365 days for members age 21 and older • preventive services including prophylaxis, fluoride for members under age 21, sealants, and space maintainers • routine radiographs/diagnostic imaging • comprehensive dental services including non-routine diagnostic, restorative, endodontic, periodontic, prosthodontic, prosthodontic, maxillofacial prosthetics, implant services, orthodontic, and surgery services <p>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.</p>	
<p>Depression screening</p> <p>The plan covers depression screening.</p>	



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Services covered by our plan	Limitations and exceptions
<p>Diabetes screening</p> <p>The plan covers diabetes screening (includes fasting glucose tests).</p> <p>You may want to speak to your provider about this test if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, family history of diabetes, or history of high blood sugar (glucose).</p> <p>You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p>	
<p>Glaucoma screening</p> <p>The plan covers one glaucoma screening each year for members under the age of 20 or age 50 and older, members with a family history of glaucoma, and members with diabetes.</p>	
<p>HIV screening</p> <p>The plan covers HIV screening exams for people who ask for an HIV screening test or are at increased risk for HIV infection.</p>	



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Services covered by our plan	Limitations and exceptions
<p>Immunizations</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Vaccines for children under age 21 • Pneumonia vaccine • Flu/influenza vaccine, once each flu/influenza season in the fall and winter, with additional flu/influenza vaccine shots if medically necessary • Hepatitis B vaccines 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 or Medicaid coverage rules • Other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 to learn more. 	
<p>Lung cancer screening</p> <p>The plan will pay for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> • Are aged 55-77, 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. 	<p>After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.</p>
<p>Medicare Diabetes Prevention Program (MDPP)</p> <p>The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none"> • long-term dietary change, and • increased physical activity, and • ways to maintain weight loss and a healthy lifestyle. 	

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Services covered by our plan	Limitations and exceptions
<p>Obesity screening and therapy to keep weight down</p> <p>The plan covers counseling to help you lose weight. Talk to your primary care provider to find out more.</p>	<p>You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan.</p>
<p>Prostate cancer screening</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • A digital rectal exam • A prostate specific antigen (PSA) test 	
<p>Sexually transmitted infections (STIs) screening and counseling</p> <p>The plan covers screenings for sexually transmitted infections, including but not limited to chlamydia, gonorrhea, syphilis, and hepatitis B.</p> <p>The plan also covers face-to-face, high-intensity behavioral counseling sessions for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long.</p>	<p>A primary care provider must order the tests.</p> <p>The plan covers these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor’s office.</p>



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section D3 Other services

Services covered by our plan	Limitations and exceptions
<p>Acupuncture</p> <p>The plan covers acupuncture for pain management of headaches, lower back pain, neck pain, osteoarthritis of the hip or knee, nausea or vomiting related to pregnancy or chemotherapy, and acute post-operative pain.</p> <p>The plan will also pay for up to 12 visits in 90 days if you have chronic low back pain, defined as:</p> <ul style="list-style-type: none"> • 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. <p>The plan will pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments each year for chronic low back pain.</p> <p>Acupuncture treatments for chronic low back pain must be stopped if you don't get better or if you get worse.</p>	<p>PA is required for more than 30 acupuncture visits per benefit year.</p>
<p>Ambulance and wheelchair van services</p> <p>Covered emergency ambulance transport services include ground and air (airplane and helicopter) ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or, if you are pregnant, your unborn baby's life or health.</p> <p>In cases that are not emergencies, ambulance or wheelchair van transport services are covered when medically necessary.</p>	<p>PA is required for air ambulance services in cases that are not emergencies. Network provider must be used in non-emergencies. Please call your Care Manager.</p>

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Services covered by our plan	Limitations and exceptions
<p>Chiropractic services</p> <p>The plan covers:</p> <ul style="list-style-type: none"> • Evaluation and exams • Diagnostic X-rays • Adjustments of the spine to correct alignment 	<p>PA is needed after 30 visits for those under 21. For members over age 21 the calendar year limit is 15 visits.</p>
<p>Dental services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Oral exam twice annually for members age 20 and under. Oral exam every year for members age 21 and over. • Preventive services including prophylaxis, fluoride for members under age 21, sealants (ages 5–20), and space maintainers • Routine radiographs/diagnostic imaging • Comprehensive dental services usually covered by Medicaid including non-routine, diagnostic, extractions, restorative, endodontic, periodontic, prosthodontic, orthodontic, and surgery services. Comprehensive dental services must be medically necessary. <p>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.</p>	<p>Fluoride treatment is only mandated for members under age 21 (once every 180 days)</p> <p>PA may be needed for comprehensive dental services.</p>



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Services covered by our plan	Limitations and exceptions
<p>Diabetic services</p> <p>The plan covers the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> • Training to manage your diabetes, in some cases • Supplies to monitor your blood glucose: Continuous glucose monitor, blood glucose monitors, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. <p>UnitedHealthcare Connected® for MyCare Ohio covers any blood glucose monitors and test strips specified within the list to the right. We will generally not cover alternate brands unless your doctor or other provider tells us that use of an alternate brand is medically necessary in your specific situation. If you are new to our plan and are using a brand of blood glucose monitors and test strips that are not on our list, you may contact us within the first 90 days of enrollment into the plan to request a temporary supply of the alternate brand while you consult with your doctor or other provider. During this time, you should talk with your doctor to decide whether any of the preferred brands are medically appropriate for you.</p> <ul style="list-style-type: none"> • If you or your doctor believes it is medically necessary for you to maintain use of an alternate brand, you may request a coverage exception to have us maintain coverage of a non-preferred product through the end of the benefit year. Non-preferred products will not be covered following the initial 90 days of the benefit year without an approved coverage exception. • If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, refer to Chapter 9, What to do if you have a problem or complaint (coverage decisions, appeals, complaints). <p>This benefit is continued on the next page</p>	<p>We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch®Ultra 2, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan.</p>

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Services covered by our plan	Limitations and exceptions
<p>Diabetic services (continued)</p> <ul style="list-style-type: none"> • For people with diabetes who have severe diabetic foot disease: <ul style="list-style-type: none"> – One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, or – One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) <p>The plan also covers fitting the therapeutic custom-molded shoes or depth shoes.</p> <p>The plan covers training to help you manage your diabetes at ADA certified Diabetic Education Centers.</p>	



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Services covered by our plan	Limitations and exceptions
<p>Durable medical equipment (DME) and related supplies Covered DME includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> • Wheelchairs • Crutches • Powered mattress systems • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps • Nebulizers • Oxygen equipment and supplies • Walkers • Speech generating devices <p>Other items (such as incontinence garments, enteral nutritional products, ostomy and urological supplies, and surgical dressings and related supplies) may be covered. For incontinence supplies only, you must use the preferred provider. For additional types of supplies that the plan covers, refer to the sections on diabetic services, hearing services, and prosthetic devices.</p> <p>The plan may also cover learning how to use, modify, or repair your item. Your care team will work with you to decide if these other items and services are right for you and will be in your Individualized Care Plan.</p> <p>We will cover all DME that Medicare and Medicaid usually cover. 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.</p>	<p>PA is needed for items over \$1,000. There may be other Medicare or Medicaid items that require PA. Please call your Care Manager or the ordering provider. Before you receive DME equipment or supplies, certain services may need to be ordered.</p>

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Services covered by our plan	Limitations and exceptions
<p>Emergency care (refer to also “urgently needed care”)</p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> • given by a provider trained to give emergency services, and • needed to treat a medical emergency. <p>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:</p> <ul style="list-style-type: none"> • serious risk to your health or if pregnant, to that of your unborn child; or • serious harm to bodily functions; or • serious dysfunction of any bodily organ or part; or • in the case of a pregnant woman in active labor, when: <ul style="list-style-type: none"> – there is not enough time to safely transfer you to another hospital before delivery. – a transfer to another hospital may pose a threat to your health or to that of your unborn child. <p>In an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting.</p> <p>This coverage is within the U.S. and its territories only.</p>	<p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, we will work with the doctor who wants you to stay to do what is best for you. The doctor needs to call us right away (within 24 hours).</p>

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Services covered by our plan	Limitations and exceptions
<p>Family planning services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Family planning supplies (condom, sponge, foam, film, diaphragm, cap) • Counseling and diagnosis of infertility, and related services • Counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions • Treatment for sexually transmitted infections (STIs) • Treatment for AIDS and other HIV-related conditions • Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • Screening, diagnosis and counseling for genetic anomalies and/or hereditary metabolic disorders • Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) <p>Note: You can get family planning services from a network or out-of-network qualified family planning provider (for example Planned Parenthood) listed in the Provider and Pharmacy Directory. You can also get family planning services from a network certified nurse midwife, obstetrician, gynecologist, or primary care provider.</p>	<p>†</p>

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Services covered by our plan	Limitations and exceptions
<p>Federally qualified health centers</p> <p>The plan covers the following services at Federally Qualified Health Centers:</p> <ul style="list-style-type: none"> • Office visits for primary care and specialist services • Physical therapy services • Speech pathology and audiology services • Dental services • Podiatry services • Optometric and/or optician services • Chiropractic services • Transportation services • Mental health services 	<p>Mental health services may be obtained from a network or out-of-network federally qualified health center</p>
<p>Healthy food card coverage</p> <p>With this benefit, you'll get a single prepaid card at the start of the plan year, to get healthy groceries at no cost. The prepaid card can be used at participating retailers. This is an in-store benefit. The prepaid card is loaded with credits every month to buy approved grocery items which include fruits and vegetables, dairy products, beans, bread, fish, poultry and more. Credits cannot be used to purchase tobacco or alcohol.</p>	<p>Monthly credit is \$25. Unused credits expire at the end of each month. You can get more information at myuhc.com/CommunityPlan, UHCCommunityPlan.com, or by calling Member Services 1-877-542-9236 (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week)</p>



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Services covered by our plan	Limitations and exceptions
<p>Hearing services and supplies</p> <p>The plan covers the following:</p> <ul style="list-style-type: none"> • Hearing exams, hearing and balance tests to determine the need for treatment (covered as outpatient care when you get them from a physician, audiologist, or other qualified provider) • Hearing aids, batteries, and accessories (including repair and/or replacement) <ul style="list-style-type: none"> – Two conventional hearing aids are covered once every 4 years - OR - – Two digital/programmable hearing aids are covered once every 5 years 	<p>Items over \$1,000 require PA.</p>



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Services covered by our plan	Limitations and exceptions
<p>Home and community-based waiver services</p> <p>The plan covers the following home and community-based waiver services:</p> <ul style="list-style-type: none"> • Adult day health services • Alternative meals service • Assisted living services • Choices home care attendant • Chore services • Community transition • Emergency response services • Enhanced community living services • Home care attendant • Home delivered meals • Home medical equipment and supplemental adaptive and assistive device • Home modification, maintenance, and repair • Homemaker services • Independent living assistance • Nutritional consultation • Out-of-home respite services • Personal care services • Pest control • Social work counseling • Waiver nursing services • Waiver transportation <p>This benefit is continued on the next page</p>	<p>These services are available only if your need for long-term care has been determined by the Ohio Department of Medicaid.</p> <p>You may be responsible for paying a patient liability for waiver services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.</p> <p>Assisted living services are limited to one unit per calendar day.</p> <p>Choices home care attendant cannot be used at the same time as personal care services.†</p>

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Services covered by our plan	Limitations and exceptions
<p>Home and community-based waiver services (continued)</p> <p>This benefit is continued on the next page</p>	<p>Community Transition service is only available if you are unable to meet such expenses or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household appliances or items that are intended for purely diversion/recreational purposes.</p> <p>Emergency Response Services (ERS) does not include the following:</p> <ul style="list-style-type: none"> • Equipment that connects you directly to 911. • Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment or supplies, regardless of whether such equipment is connected to the ERS equipment. • Remote monitoring services. • Services performed in excess of what is approved for your waiver services plan.



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Services covered by our plan	Limitations and exceptions
<p>Home and community-based waiver services (continued)</p>	<ul style="list-style-type: none"> • New equipment or repair of previously-approved equipment that has been damaged as a result of confirmed misuse, abuse or negligence. <p>Home Medical Equipment & Supplemental Adaptive and Assistive Devices shall not exceed a combined total of \$10,000 within a calendar year per individual which includes vehicle modifications.</p> <p>Home Modification Maintenance & Repair is limited to \$10,000 per twelve-month calendar year.</p>
<p>Home health services</p> <p>The plan covers the following services provided by a home health agency:</p> <ul style="list-style-type: none"> • Home health aide and/or nursing services • Physical therapy, occupational therapy, and speech therapy • Private duty nursing (may also be provided by an independent provider) • Home infusion therapy for the administration of medications, nutrients, or other solutions intravenously or enterally • Medical and social services • Medical equipment and supplies 	<p>Additional hours over the State Medicaid Plan services of 14 hours per week require PA.</p> <p>PA may be required for some HomeHealth Services. Please call your Care Manager or Member Services.</p>



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Services covered by our plan	Limitations and exceptions
<p>Home infusion therapy</p> <p>The plan will pay for home infusion therapy, defined as drugs administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:</p> <ul style="list-style-type: none"> • The drug, such as an antiviral or immune globulin; • Equipment, such as a pump; and • Supplies, such as tubing or a catheter. <p>The plan will cover home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"> • 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. 	



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Services covered by our plan	Limitations and exceptions
<p>Hospice care</p> <p>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 a hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>The plan will cover the following while you are getting hospice services:</p> <ul style="list-style-type: none"> • Drugs to treat symptoms and pain • Short-term respite care • Home care • Nursing facility care <p>Hospice services and services covered by Medicare Part A or B are billed to Medicare:</p> <ul style="list-style-type: none"> • Refer to section F of this chapter for more information. <p>This benefit is continued on the next page</p>	<p>If you want hospice services in a nursing facility, you may be required to use a network nursing facility. Also, you may be responsible for paying a patient liability for nursing facility services, after the Medicare nursing facility benefit is used. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.</p>

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Services covered by our plan	Limitations and exceptions
<p>Hospice care (continued)</p> <p>For services covered by UnitedHealthcare Connected® for MyCare Ohio but not covered by Medicare Part A or B:</p> <ul style="list-style-type: none"> • UnitedHealthcare Connected® for MyCare Ohio will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. Unless you are required to pay a patient liability for nursing facility services, you pay nothing for these services. <p>For drugs that may be covered by UnitedHealthcare Connected® for MyCare Ohio’s Medicare Part D benefit:</p> <p>Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5.</p> <p>Note: Except for emergency/urgent care, if you need non-hospice care, you should call your Care Manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Please call your Care Manager directly or call Member Services at 1-877-542-9236, 8 a.m.–8 p.m. local time, Monday–Friday and ask to be transferred to Care Management. After hours, please call 1-800-542-8630.</p> <p>Our plan covers hospice consultation services for a terminally ill person who has not chosen the hospice benefit.</p>	
<p>Inpatient behavioral health services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Inpatient psychiatric treatment in an Institution for Mental Disease (IMD) for members 65 years of age and older. <ul style="list-style-type: none"> – For members ages 21 through 64, the plan covers inpatient psychiatric treatment in an Institution for Mental Disease (IMD) for up to 15 days per calendar month. • Inpatient detoxification care 	<p>Medical necessity review is required to determine if care in the hospital is medically necessary. We will continue to review the care you are receiving once you are in the hospital to make sure it is still the right place for you.</p> <p>PA is needed. Please talk to your Care Manager or Member Services.</p>

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Services covered by our plan	Limitations and exceptions
<p>Inpatient hospital care</p> <p>The plan covers the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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 for use in the hospital • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance use disorder services • Blood, including storage and administration beginning with the first pint • Physician/provider services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant.</p> <p>This benefit is continued on the next page</p>	<p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient.” This is called an “Outpatient Observation” stay. If you are not sure if you are an inpatient or outpatient, you should ask your doctor or the hospital staff.</p> <p>PA is required to determine if care in the hospital is medically necessary. We will continue to review the care you are receiving once you are in the hospital to make sure it is still the right place for you.</p>

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Services covered by our plan	Limitations and exceptions
<p>Inpatient hospital care (continued)</p> <p>Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If UnitedHealthcare Connected® for MyCare Ohio provides transplant services at a distant location outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.</p>	
<p>Kidney disease services and supplies</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help you make good decisions about your care • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible • Inpatient dialysis treatments if you are 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 <p>Note: Your Medicare Part B drug benefit covers some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart.</p>	

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Services covered by our plan	Limitations and exceptions
<p>Medical nutrition therapy</p> <p>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.</p> <p>The plan covers three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover two hours of one-on-one counseling services each year after that.</p> <p>Under your Medicaid coverage, the plan covers counseling on medical nutrition by your PCP.</p>	<p>You may be able to get counseling if you do not have diabetes or kidney disease. Please ask your Care Manager for more information.</p> <p>If you have diabetes or kidney disease, talk to your Care Manager if you want more hours of counseling.</p>



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Services covered by our plan	Limitations and exceptions
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Medicare. UnitedHealthcare Connected® for MyCare Ohio covers the following drugs that may be subject to step therapy:</p> <ul style="list-style-type: none"> • Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi (generic lecanemab) which is given intravenously (IV) • Clotting factors you give yourself by injection if you have hemophilia • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv, and the oral medication Sensipar • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B does not cover them 	<p>†</p>

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Services covered by our plan	Limitations and exceptions
<p>Medicare Part B prescription drugs (continued)</p> <ul style="list-style-type: none"> • 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 • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs and anti-nausea drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions • IV immune globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (IV and tube feeding) <p>The following link will take you to a list of Part B drugs that may be subject to step therapy: medicare.uhc.com/medicare/member/documents/part-b-step-therapy.html</p> <p>This benefit is continued on the next page</p> <p>We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit.</p>	

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Services covered by our plan	Limitations and exceptions
<p>Medicare Part B prescription drugs (continued)</p> <p>Chapter 5 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p>Chapter 6 explains what you pay for your outpatient prescription drugs through our plan.</p>	
<p>Mental health and substance use disorder services at addiction treatment centers</p> <p>The plan covers the following services at addiction treatment centers:</p> <ul style="list-style-type: none"> • Ambulatory detoxification • Assessment • Case management • Counseling • Crisis intervention • Intensive outpatient • Alcohol/drug screening analysis/lab urinalysis • Medical/somatic • Methadone administration • Office administered medications for addiction including vivitrol and buprenorphine induction <p>Refer to “Inpatient behavioral health services” and “Outpatient mental health care” for additional information.</p>	<p>†</p>

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Services covered by our plan	Limitations and exceptions
<p>Mental health and substance use disorder treatment services at community mental health centers</p> <p>The plan covers the following services at certified community mental health centers:</p> <ul style="list-style-type: none"> • Mental health assessment/diagnostic psychiatric evaluation • Assertive Community Treatment (ACT) • Intensive Home Based Treatment (IHBT) • Screening, Brief Intervention and Referral to Treatment (SBIRT) • Psychological Testing • Therapeutic Behavioral Services (TBS) • Psychosocial Rehabilitation • Community psychiatric supportive treatment (CPST) services • Counseling and therapy • Crisis intervention • Pharmacological management • Certain office administered injectable antipsychotic medications • Partial hospitalization for Substance Use Disorder (SUD) only <p>Partial hospitalization is a structured program of active substance use disorder 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, licensed marriage and family therapist’s (LMFT), or licensed professional counselor’s office. Refer to “Inpatient behavioral health services” and “Outpatient mental health care” for additional information.</p>	<p>PA needed for Partial hospitalization.</p> <p>PA is needed for ACT as well as SUD partial hospitalization and residential care after initial limits are met.</p>



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Services covered by our plan	Limitations and exceptions
<p>Nursing and skilled nursing facility (SNF) care</p> <p>The plan covers the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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 beginning with the first pint of blood • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Durable medical equipment, such as wheelchairs, usually given by nursing facilities • Physician/provider services <p>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 Medicaid nursing facility care from the following place if it accepts our plan’s amounts for payment:</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you lived on the day you became a UnitedHealthcare Connected® for MyCare Ohio member <p>This benefit is continued on the next page</p>	<p>You may be responsible for paying a patient liability for room and board costs for nursing facility services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.</p> <p>Note that patient liability does not apply to Medicare-covered days in a nursing facility.</p> <p>PA is required to determine if care in the nursing/skilled nursing facility is medically necessary. We will continue to review the care you are receiving once you are in the nursing/skilled nursing facility to make sure it is still the right place for you.</p> <p>3-day inpatient hospital stay is waived.</p>

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Services covered by our plan	Limitations and exceptions
<p>Nursing and skilled nursing facility (SNF) care (continued)</p> <p>You can get Medicare nursing facility care from the following places if they accept our plan’s amounts for payment:</p> <ul style="list-style-type: none"> • A nursing home 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 	
<p>Opioid treatment program (OTP) services</p> <p>The plan will pay for the following services to treat opioid use disorder (OUD):</p> <ul style="list-style-type: none"> • Intake activities • Periodic assessments • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use disorder counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing) 	<p>There is no coinsurance, copayment, or deductible.</p> <p>Additional coverage may be available based on the Medicaid portion of the plan’s coverage.</p>

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Services covered by our plan	Limitations and exceptions
<p>Outpatient mental health care</p> <p>The plan covers mental health services provided by:</p> <ul style="list-style-type: none"> • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical counselor, • a family and marriage therapist, • a clinical nurse specialist, • a licensed professional counselor (LPC), • a licensed marriage and family therapist (LMFT), • a nurse practitioner (NP), • a physician assistant, or • any other qualified mental health care professional as allowed under applicable state laws. <p>The plan covers the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Clinic services and general hospital outpatient psychiatric services • Therapeutic Behavioral Services (TBS) • Psychosocial rehab services <p>Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor’s, therapist’s, LMFT, or licensed professional counselor’s office but less intense than partial hospitalization.</p>	

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Services covered by our plan	Limitations and exceptions
<p>Outpatient services</p> <p>The plan covers services you get in an outpatient setting for diagnosis or treatment of an illness or injury.</p> <p>The following are examples of covered services:</p> <ul style="list-style-type: none"> • 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: es.medicare.gov/publications/11435-MedicareHospital-Benefits.pdf. • The plan covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers • Chemotherapy • Labs and diagnostic tests (for example urinalysis) • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • Imaging (for example X-rays, CTs, MRIs) • Radiation (radium and isotope) therapy, including technician materials and supplies • Blood, including storage and administration beginning with the first pint • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself 	<p>PA may be needed for certain procedures and tests, such as genetic testing, MRIs, MRAs, PET scans, nuclear medicine studies (including nuclear cardiology), outpatient surgical procedures, as well as chemotherapy and other outpatient infusion therapies. Please talk to your Care Manager or Member Services.</p>

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Services covered by our plan	Limitations and exceptions
Outpatient drugs Please read Chapter 5 for information on drug benefits, and Chapter 6 for information on what you pay for drugs.	†
Over-the-counter (OTC) drugs based on our formulary Select prescription and OTC drugs listed on the UnitedHealthcare Connected® MyCare Ohio Drug List not covered under the Medicare Part D benefit.	†



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Services covered by our plan	Limitations and exceptions
<p>Physician/provider services, including doctor’s office visits</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Free standing birth center services • Health care or surgery services given in places such as a physician’s office, certified ambulatory surgical center, or hospital outpatient department • Consultation, diagnosis, and treatment by a specialist • Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in rural areas or other places approved by Medicare • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of their location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • 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 for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> – You have an in-person visit within 6 months prior to your first telehealth visit – You have an in-person visit every 12 months while receiving these telehealth services – Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers <p>This benefit is continued on the next page</p>	<p>24/7 On-line Provider Directory and On-line Member Website available. Provider Services 8 a.m.–6 p.m. local time, Monday–Friday. Member Services 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24/7). Access to Care Manager 8 a.m.–7 p.m. and additionally between the hours of 7 p.m. and 8 a.m. through Nursing Hotline Services available 24/7.†</p>



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Services covered by our plan	Limitations and exceptions
<p>Physician/provider services, including doctor’s office visits (continued)</p> <ul style="list-style-type: none"> • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> – 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: <ul style="list-style-type: none"> – 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: <ul style="list-style-type: none"> – surgery of the jaw or related structures, – setting fractures of the jaw or facial bones, – pulling teeth before radiation treatments of neoplastic cancer, – oral exams before a kidney transplant, or – services that would be covered when provided by a physician. 	

? If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Services covered by our plan	Limitations and exceptions
<p>Our plan covers certain telehealth services beyond Original Medicare, including:</p> <ul style="list-style-type: none"> • Additional virtual medical visits: <ul style="list-style-type: none"> – Urgently needed services – Primary care provider – Specialist – Other non-physician health care professional or a nurse practitioner • Additional virtual visits for individual mental health therapy sessions: <ul style="list-style-type: none"> – Outpatient mental health care – Outpatient substance use disorder services – You can access your virtual mental health visits even if you haven't had an in-person visit previously • Virtual visits are medical or mental health visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/video capabilities. • You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a provider who offers the service by telehealth. • Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment. • Telehealth services not covered by Medicare and not listed above are not covered. 	<p>\$0 Out-of-network not covered</p>

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Services covered by our plan	Limitations and exceptions
<p>Podiatry services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • Diagnosis and medical or surgical treatment of injuries and diseases of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma • Routine foot care for members with conditions affecting the legs, such as diabetes 	<p>Certain services may require authorization.</p>
<p>Prosthetic and orthotic devices and related supplies</p> <p>Prosthetic devices replace all or part of a body part or function. These include but are not limited to:</p> <ul style="list-style-type: none"> • Testing, fitting, or training in the use of prosthetic and orthotic devices • Colostomy bags and supplies related to colostomy care • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Dental devices <p>The plan also covers some supplies related to prosthetic and orthotic devices and the repair or replacement of prosthetic and orthotic devices.</p> <p>The plan offers some coverage after cataract removal or cataract surgery. Refer to “Vision Services” later in this section for details.</p>	<p>PA is needed for items over \$1,000. There may be other items that require PA. Please call your Care Manager or the ordering provider. Before you receive certain services, PA may be required. Network provider should be used.</p>

? If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Services covered by our plan	Limitations and exceptions
<p>Rehabilitation services</p> <ul style="list-style-type: none"> • Outpatient rehabilitation services <ul style="list-style-type: none"> – The plan covers 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. • Cardiac (heart) rehabilitation services <ul style="list-style-type: none"> – The plan covers cardiac rehabilitation services such as exercise, education, and counseling for certain conditions. – The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. • Pulmonary rehabilitation services <ul style="list-style-type: none"> – The plan covers pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). 	<p>†</p>
<p>Rural health clinics</p> <p>The plan covers the following services at Rural Health Clinics:</p> <ul style="list-style-type: none"> • Office visits for primary care and specialist services • Clinical psychologist • Clinical social worker for the diagnosis and treatment of mental illness • Visiting nurse services in certain situations <p>Note: You can get services from a network or out-of-network Rural Health Clinic.</p>	



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com**.

Services covered by our plan	Limitations and exceptions
<p>Specialized Recovery Services (SRS) program</p> <p>If you are an adult who has been diagnosed with a severe and persistent mental illness and you live in the community, you may be eligible to get SRS specific to your recovery needs. The plan covers the following three services if you are enrolled in the SRS program:</p> <ul style="list-style-type: none"> • Recovery management—Recovery managers will work with you to: <ul style="list-style-type: none"> – Develop a person-centered care plan which reflects your personal goals and desired outcomes, – Regularly monitor your plan through regular meetings, and – Provide information and referrals. • Individualized Placement and Support-Supported Employment (IPS-SE)—Supported employment services can: <ul style="list-style-type: none"> – Help you find a job if you are interested in working, – Evaluate your interests, skills, and experiences as they relate to your employment goals, and – Provide ongoing support to help you stay employed. • Peer recovery support: <ul style="list-style-type: none"> – Peer recovery supporters use their own experiences with mental health and substance use disorders to help you reach your recovery goals, and – Goals are included in a care plan you design based on your preferences and the availability of community and supports. <p>The peer relationship can help you focus on strategies and progress towards self-determination, self-advocacy, well-being and independence.</p>	<p>If you are interested in SRS, you will be connected with a recovery manager who will begin the assessment for eligibility looking at things such as your diagnosis and your need for help with activities such as medical appointments, social interactions and living skills.</p>

? If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Services covered by our plan	Limitations and exceptions
<p>Supervised Exercise Therapy (SET)</p> <p>The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for:</p> <ul style="list-style-type: none"> • 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 <p>The SET program must be:</p> <ul style="list-style-type: none"> • 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 	
<p>Transportation for non-emergency services (also refer to “Ambulance and wheelchair van services”)</p> <p>Covered non-emergency ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care.</p> <p>If you <u>must</u> travel 30 miles or more from your home to get covered health care services, UnitedHealthcare Connected® for MyCare Ohio will provide transportation to and from the provider’s office.</p>	<p>Reservations are required and you must also have a scheduled appointment (except in the case of urgent/emergent care). Please contact Member Services at 1-877-542-9236 (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voice mail available 24 hours a day, 7 days a week) at least 48 hours in advance of your appointment for assistance.</p>

? If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Services covered by our plan	Limitations and exceptions
<p>Transportation for non-emergency services (also refer to “Ambulance and wheelchair van services”) (continued)</p> <p>Must use designated in-network provider. May offer bus tokens or vouchers. Authorization is required for trips over 60 miles (one-way), and will require prior approval by Health Plan staff.</p> <p>Mileage reimbursement may be available with appropriate documentation and request.</p> <p>Select modes of transportation for Plan Approved Health-related locations include:</p> <ul style="list-style-type: none"> • Taxi • Rideshare Services • Bus/Subway • Van • Medical Transport. <p>Additional transportation available to critical care trip types: dialysis, chemotherapy, radiation, wound care, substance abuse and pregnancy.</p> <p>Note: In addition to the transportation assistance that UnitedHealthcare Connected® for MyCare Ohio provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services.</p>	<p>Limited to 30 one-way trips every year to a Plan approved health-related location.</p> <p>Please refer to the waiver transportation benefit if you qualify for waiver services.</p> <p>Reservations are required and you must also have a scheduled appointment (except in the case of urgent/emergent care). Please contact Member Services at 1-877-542-9236 (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voice mail available 24 hours a day, 7 days a week) at least 48 hours in advance of your appointment for assistance.</p>

? If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Services covered by our plan	Limitations and exceptions
<p>Urgently needed care</p> <p>Urgently needed care is given to treat:</p> <ul style="list-style-type: none"> • a non-emergency, or • an unforeseen medical illness, or • an injury, or • a condition that needs care right away. <p>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 time, place, or 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).</p> <p>Coverage is within the U.S. and its territories only.</p>	



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Services covered by our plan	Limitations and exceptions
<p>Vision care</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> • One comprehensive eye exam, complete frame, and pair of lenses (contact lenses, if medically necessary) are covered: <ul style="list-style-type: none"> – per 12-month period for members under 21 and over 59 years of age; or – per 24-month period for members 21 through 59 years of age. <p>PA may be required for certain conditions or material types.</p> <ul style="list-style-type: none"> • Vision training • Services for the diagnosis and treatment of diseases and injuries of the eye, including but not limited to: <ul style="list-style-type: none"> – Annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration – One glaucoma screening each year for members under the age of 20 or age 50 and older, members with a family history of glaucoma, members with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are age 65 and older. – One pair of standard 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.) 	

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section E Services when you are away from home or outside of the service area

If you are away from home or outside of our service area (refer to Chapter 1) and need medical care please contact your PCP's office for assistance. Remember, if it's an emergency you should go to the nearest ER or call 911. You can also get urgent care services from an out-of-network provider if a network provider is not available where you are. Both emergency and urgent care services are only available within the U.S. and its territories.

Section F Benefits covered outside of UnitedHealthcare Connected® for MyCare Ohio

The following services are not covered by UnitedHealthcare Connected® for MyCare Ohio but are available through Medicare. Call Member Services to find out about services not covered by UnitedHealthcare Connected® for MyCare Ohio but available through Medicare.

Section F1 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 UnitedHealthcare Connected® for MyCare Ohio pays for while you are getting hospice care services.

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

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

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

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

For drugs that may be covered by UnitedHealthcare Connected® for MyCare Ohio's Medicare Part D benefit:



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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

Note: If you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. If you need to speak to your care manager, please call **1-800-542-8630**, 24 hours a day, 7 days a week. These calls are free.

Section G Benefits not covered by UnitedHealthcare Connected® for MyCare Ohio, Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that the plan does not cover these benefits. Medicare and Medicaid will 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.

The plan will not cover the 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 we should cover a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9.

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 Medicaid, 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, pages 41-42, 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 covers 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
- Inpatient hospital custodial care
- Full-time nursing care in your home
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- 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, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it
- Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Infertility services for males or females
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure
- Reversal of sterilization procedures, penile prostheses, and non-prescription contraceptive supplies
- Paternity testing
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother
- Naturopath services (the use of natural or alternative treatments)
- Services provided to veterans in Veterans Affairs (VA) facilities
- Services to find cause of death (autopsy)
- Equipment or supplies that condition the air, wigs, and their care, and other primarily non-medical equipment
- Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which do not provide ambulance transport), unless Medicare criteria are met
- Immunizations for foreign travel purposes



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **[UHCCommunityPlan.com](https://www.uhccommunityplan.com)**.

Chapter 5

Getting your outpatient prescription drugs through the plan

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 Medicaid. Chapter 6 tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

UnitedHealthcare Connected® for MyCare Ohio also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some 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.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

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

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

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

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

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

Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical references.

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section A Getting your prescriptions filled

Section A1 Filling your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions **only** if they are filled at the plan's network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, you can look in the **Provider and Pharmacy Directory**, visit our website, or contact Member Services.

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 will bill the plan for your covered prescription drug. If you have a copay for a drug, you may need to pay the pharmacy the copay when you pick up your prescription. If you cannot pay for the drug, contact Member Services, or ask the pharmacist to call UnitedHealthcare Connected® for MyCare Ohio's pharmacy help desk right away. We will do what we can to help.

You should **always** show the pharmacy your Member ID Card when you fill a prescription to avoid any problems. If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information, or you can ask the pharmacy to look up your plan enrollment information.

If you need help getting a prescription filled, you can contact Member Services.

Section A3 What to do if you change a prescription to a different network pharmacy

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

If you need help finding a network pharmacy, you can contact Member Services.

Section A4 What to do if your pharmacy leaves the network

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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

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 home.
 - Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must 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 accessing your drug benefits in a long-term care facility, please contact Member Services.
- 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, you can look in the **Provider and Pharmacy Directory**, visit our website, or contact Member Services.

Section A6 **Using mail-order services to get your drugs**

Our plan’s mail-order service allows you to order up to a 90-day supply. A 31-day supply has the same copay as a one-month supply.

Filling my prescriptions by mail

To get order forms and information about Optum filling your prescriptions by mail, contact our mail service pharmacy, Optum Rx. Optum Rx can be reached at **1-877-889-6358**, or for the hearing impaired, (TTY) **711**, 24 hours a day, 7 days a week.

Optum® Home Delivery Pharmacy and Optum Rx are affiliates of UnitedHealthcare Insurance Company. You are not required to use Optum Home Delivery Pharmacy for medications you take regularly. If you have not used Optum Home Delivery Pharmacy, you must approve the first prescription order sent directly from your doctor to the pharmacy before it can be filled. Prescriptions from the pharmacy should arrive within 5 business days after we receive the complete order. There may be other pharmacies in our network.

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

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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 or provider to call in a new prescription to your pharmacist. Or, your pharmacist can call the doctor's office for you to request the prescription. Your pharmacist can call the pharmacy help desk at **1-877-889-6481** if they have 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:

- **New prescriptions the pharmacy gets from you**

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

- **New prescriptions the pharmacy gets directly from your provider's office**

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

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

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

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

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

This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped.

It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

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

- **Refills on mail-order prescriptions**



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

For refills, please contact your pharmacy at least ten business days before your current prescription will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. You should ask the Pharmacy the best way to give them your preference.

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 31-day supply has the same copay as a one-month supply. The **Provider and Pharmacy Directory** tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

You can use the plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to the section above to learn about mail-order services.

Section A8 **Using a pharmacy that is not in the plan's 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. In these cases, check with Member Services first to find out if there's a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

We will 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, and are included in our **Drug List**. Any restrictions will still apply.

- Coverage when traveling or out of the service area

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

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- If you are traveling within the United States or its territories and become ill or run out of or lose your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules.
- If you are 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.
- During a declared disaster, if you get a prescription filled at an out-of-network pharmacy, please call us so we can help you obtain reimbursement for any out of pocket expense you might have incurred, excluding any applicable copay.
- If you are trying to fill a prescription drug not regularly stocked at an accessible network retail or network mail-order pharmacy (including high cost and unique drugs).
- If you need a prescription while a patient in an emergency department, provider based clinic, outpatient surgery, or other outpatient setting.

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

If you use an out-of-network pharmacy, you may have to pay the full cost instead of a copay when you get your prescription.

If you were unable to use a network pharmacy and had to pay for your prescription, refer to Chapter 7.

Section B The plan's Drug List

The plan has a **List of Covered Drugs**. We call it the “**Drug List**” for short.

The drugs on the **Drug List** are selected by the plan with the help of a team of doctors and pharmacists. The **Drug List** also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's **Drug List** as long as you follow the rules explained in this chapter.

Section B1 Drugs on the Drug List

The **Drug List** includes the drugs covered under Medicare Part D and some prescription and over-the-counter drugs covered under your Medicaid benefits.

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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

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

We will generally cover a drug on the plan’s **Drug List** as long as you follow the rules explained in this chapter.

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

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter 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 are taking is on the **Drug List**, you can:

- Check the most recent **Drug List** we sent you in the mail.
- Visit the plan’s website at **UHCommunityPlan.com**. The **Drug List** on the 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 your care coordinator or 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 that are not on the Drug List**

The plan does not cover all prescription drugs. Some drugs are not on the **Drug List** because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the **Drug List**.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

UnitedHealthcare Connected® for MyCare Ohio will not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, refer to Chapter 9.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by UnitedHealthcare Connected® for MyCare Ohio for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration or supported by certain medical references as a treatment for your condition. Your doctor or other provider might 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, the types of drugs listed below are not covered by Medicare or Medicaid.

- 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, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs when the company who makes the drugs says that you have to have tests or services done only by them

Section B4 Drug List cost sharing tiers

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

- Tier 1 drugs have the lowest copay. They are generic drugs. The copay will be from \$0 to \$4.90, depending on your income level.
- Tier 2 drugs have the highest copay. They are brand name drugs. The copay will be from \$0 to \$12.15, depending on your income level.
- Tier 3 drugs have a copay of \$0. They are OTCs/Non-Part D Drugs.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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

Section C Limits on some drugs

For certain prescription drugs, special rules limit how and when the plan covers them. In general, 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 will work just as well as a higher-cost drug, the plan expects 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 will have to 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 think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, refer to Chapter 9.

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

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

- We usually will not pay for the brand name drug when there is a generic version.
- However, if your provider has told us the medical reason that the generic drug or interchangeable biosimilar will not work for you or has written “No substitutions” on your prescription for a brand name drug or original biological products or has told us the medical reason that neither the generic drug or interchangeable biosimilar nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.
- Your copay may be greater for the brand name drug or original biological products than for the generic drug or interchangeable biosimilar.

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 will give you the generic version.

- We usually will not pay for the brand name drug or original biological product when there is a generic version.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- However, if your provider has told us the medical reason that the generic drug will not work for you **or** has written “No substitutions” on your prescription for a brand-name drug **or** has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.
- Your copay may be greater for the brand name or original biological products drug than for the generic drug or interchangeable biosimilar.

- **Getting plan approval in advance**

For some drugs, you or your prescriber must get approval from UnitedHealthcare Connected® for MyCare Ohio, based on specific rules before you fill your prescription. This is called Prior Authorization (PA). If you don’t get approval, UnitedHealthcare Connected® for MyCare Ohio may not cover the drug.

- **Trying a different drug first**

In general, the plan wants 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, the plan will then cover Drug B. This is called step therapy.

- **Quantity limits**

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan 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 the **Drug List**. For the most up-to-date information, call Member Services or check our website at **UHCCommunityPlan.com**.

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 would like it to be. For example:

- The drug you want to take is not covered by the plan. The drug might not be on the **Drug List**. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- The drug is covered, but there are special rules or limits on coverage for that drug. As explained in the section above, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section D1 Getting a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the **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 the plan 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 the plan’s **Drug List, or**
 - was never on the plan’s **Drug List, or**
 - is now limited in some way.
2. You must be in one of these situations:
 - You were in the plan last year.
 - We will cover a temporary supply of your drug **during the first 90 days of the calendar year.**
 - This temporary supply will be for up to at least 30 days.
 - If your prescription is written for fewer days, we will 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 the plan.
 - We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan.**
 - This temporary supply will be for up to 31 days.
 - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 31 days of medication. You must fill the prescription at a network pharmacy.
 - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
 - You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.
 - We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

? **If you have questions or need to speak with your care manager,** please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com.**

- For current members with level of care changes: There may be unplanned transitions such as hospital discharges or level of care changes that happen while you are a member in our plan. If you are prescribed a drug that is not on our **Drug List** or your ability to get your drugs is limited, you must use the plan’s exception process. You may ask for a one-time emergency supply of up at least 31 days to allow you time to discuss this with your doctor or to ask for a **Drug List** exception.
- To ask for a temporary supply of a drug, call Member Services.

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

- You can change to another drug.

There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

OR

- You can ask for an exception.

You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the **Drug List**. Or you can ask the plan 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.

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

To learn more about asking for an exception, refer to Chapter 9.

If you need help asking for an exception, you can contact Member Services.

Section E Changes in coverage for your drugs

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- Decide to require or not require prior authorization (PA) or approval for a drug. (PA is permission from UnitedHealthcare Connected® for MyCare Ohio before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally 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 the **Drug List** now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

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

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

- Check UnitedHealthcare Connected® for MyCare Ohio's up to date **Drug List** online at **UHCommunityPlan.com** **or**
- Call Member Services to check the current **Drug List** at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week).

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

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

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

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

- We may not tell you before we make this change, but we 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 this handbook for more information on exceptions.
- **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or effective or the drug's manufacturer takes a drug off the market, we may immediately take it off the **Drug List**. If you are taking the drug, we will send you a notice after we make the change. If you are notified that a drug you are taking has been taken off the market, you should talk to your doctor or other prescriber.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

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

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

When these changes happen, we will:

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

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

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

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

We may make changes to drugs you take that are not described above and do not affect you now. For such changes, if you are taking a drug 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**.

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

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

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

Section F Drug coverage in special cases

Section F1 If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to 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 rules for coverage.

To learn more about drug coverage and what you pay, refer to Chapter 6.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section F2 **If you are in a long-term care facility**

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living 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, please contact Member Services.

Section F3 **If you are 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 drugs, 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 our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, 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 should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. Refer to the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, refer to Chapter 4, Section D.

Section G **Programs on drug safety and managing drugs**

Section G1 **Programs to help members use drugs safely**

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

- May not be needed because you are taking another similar drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- Have unsafe amounts of opioid pain medications

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

Section G2 Programs to help members manage their drugs

If you take medications for different medical conditions and/or you are in a Drug Management Program to help you use your opioid medications safely, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. 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 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

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your prescriber about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members that 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 the program.

If you have any questions about these programs, please contact Member Services or your Care Manager.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section G3 **Drug management program to help members safely use their opioid medications**

UnitedHealthcare Connected® for MyCare Ohio 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 prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications 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 certain pharmacies and/or certain prescribers**
- **Limiting the amount** of those medications we will 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 prescribers 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 will send you another letter that confirms the limitations.

The DMP may not apply to you if you:

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

? **If you have questions or need to speak with your care manager,** please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com**.

Chapter 6

What you pay for your Medicare and Medicaid prescription drugs

Introduction

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

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

Because you are eligible for Medicaid, you are getting “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 the **Member Handbook**.

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

- The plan’s **List of Covered Drugs**. We call this the **Drug List**. It tells you:
 - Which drugs the plan pays for
 - Which of the three cost-sharing tiers each drug is in
 - Whether there are any limits on the drugs

If you need a copy of the **Drug List**, call Member Services. You can also find the **Drug List** on our website at **UHCCommunityPlan.com**. The **Drug List** on the website is always the most current.

- Chapter 5 of this **Member Handbook**.
 - Chapter 5, Introduction, tells how to get your outpatient prescription drugs through the plan.
 - It includes rules you need to follow. It also tells which types of prescription drugs are not covered by our plan.
- The plan’s **Provider and Pharmacy Directory**.
 - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan.
 - The **Provider and Pharmacy Directory** has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, Section A.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- 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.

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

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 has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. The EOB includes:

- **Information for the month**. The summary tells what 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 the 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. For more details on Medicare Part D out-of-pocket costs, refer to the **Drug List**. To find out which drugs our plan covers, refer to 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, and that Medicare pays for you, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your Member ID Card.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Show your Member ID Card every time you get a prescription filled. This will help us know what prescriptions you fill, what you pay, and what Medicare pays for you.

2. Make sure we have the information we need.

Give us copies of receipts for covered drugs that you have paid for. You should give us copies of your receipts when you buy covered drugs at an out-of-network pharmacy.

If you were unable to use a network pharmacy and had to pay for your prescription, refer to Chapter 7, Section A, for information about what to do.

3. Check the EOBs we send you.

When you get an **EOB** in the mail, please make sure it is complete and correct. If you think something is wrong or missing or if you have any questions, please call Member Services. Be sure to keep these EOBs. They are an important record of your drug expenses.

Section C Drug payment stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D prescription drug coverage under UnitedHealthcare Connected® for MyCare Ohio. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
During this stage, the plan pays part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, the plan pays all of the costs of your drugs through December 31, 2025. You begin this stage when you have paid a certain amount of out-of-pocket costs.

Section C1 The plan's cost-sharing tiers

Cost-sharing tiers are groups of drugs with the same copay. Every drug in the plan's **Drug List** is in one of three tiers. In general, the higher the tier number, the higher the copay. To find cost-sharing tiers for your drugs, you can look in the **Drug List**.

- Tier 1 drugs have the lowest copay. They are generic drugs. The copay is from \$0 to \$4.90 depending on your income.
- Tier 2 drugs have the highest copay. They are brand name drugs. The copay is from \$0 to \$12.15 depending on your income.

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- Tier 3 drugs have a copay of \$0. They are over-the-counter/Non-Part D drugs.

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 90-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to Chapter 5, Section A, or the **Provider and Pharmacy Directory**.

Section C3 **What you pay**

You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price. If you have a copay for a drug, you will need to pay the pharmacy the copay when you pick up your prescription. If you cannot pay for the drug, contact Member Services, or ask the pharmacist to call UnitedHealthcare Connected® for MyCare Ohio’s pharmacy help desk right away. We will do what we can to help.

You can contact Member Services to find out how much your copay is for any covered drug.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

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

	A network pharmacy A one-month or up to a 30-day supply	The plan's mail-order service A one-month or up to a 90-day supply	A network long-term care pharmacy Up to a 31-day supply	An out-of-network pharmacy Up to a 30-day supply. Coverage is limited to certain cases. Refer to Chapter 5, Section A, for details.
Tier 1 (Generic Drugs)	\$0 copay; or \$1.60 copay; or \$4.90 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$1.60 copay; or \$4.90 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$1.60 copay; or \$4.90 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$1.60 copay; or \$4.90 copay (depending on income level/ if you receive Extra Help)
Tier 2 (Brand Drugs)	\$0 copay; or \$4.80 copay; or \$12.15 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$4.80 copay; or \$12.15 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$4.80 copay; or \$12.15 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$4.80 copay; or \$12.15 copay (depending on income level/ if you receive Extra Help)
Tier 3 (OTCs/ Non-Part D Drugs)	\$0	\$0	\$0	\$0

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section D Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, the plan pays a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the copay. The copay depends on what tier the drug is in and how you get it.

Section D1 The plan's cost-sharing tiers

Cost-sharing tiers are groups of drugs with the same copay. Every drug in the plan's **Drug List** is in one of three cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, you can look in the **Drug List**.

- Tier 1 drugs have the lowest copay. They are generic drugs. The copay is from \$0 to \$4.90 depending on your income.
- Tier 2 drugs have the highest copay. They are brand name drugs. The copay is from \$0 to \$12.15 depending on your income.
- Tier 3 drugs have a copay of \$0. They are OTCs/Non-Part D drugs.

Section D2 Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 90-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to Chapter 5, Section A, or the **Provider and Pharmacy Directory**.

Section D3 What you pay

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

You can contact Member Services to find out how much your copay is for any covered drug.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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

	A network pharmacy A one-month or up to a 30-day supply	The plan's mail-order service A one-month or up to a 90-day supply	A network long-term care pharmacy Up to a 31-day supply	An out-of-network pharmacy Up to a 30-day supply. Coverage is limited to certain cases. Refer to Chapter 5, Section A for details.
Tier 1 (Generic Drugs)	\$0 copay; or \$1.60 copay; or \$4.90 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$1.60 copay; or \$4.90 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$1.60 copay; or \$4.90 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$1.60 copay; or \$4.90 copay (depending on income level/ if you receive Extra Help)
Tier 2 (Brand Drugs)	\$0 copay; or \$4.80 copay; or \$12.15 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$4.80 copay; or \$12.15 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$4.80 copay; or \$12.15 copay (depending on income level/ if you receive Extra Help)	\$0 copay; or \$4.80 copay; or \$12.15 copay (depending on income level/ if you receive Extra Help)
Tier 3 (OTC/ Non-Part D Drugs)	\$0	\$0	\$0	\$0

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section D4 End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach \$2,000. At that point, the Catastrophic Coverage Stage begins. For more details on the Catastrophic Coverage, refer to Section E below. The plan covers all your drug costs from then until the end of the year.

Your EOBs will help you keep track of how much you have paid for your drugs during the year. We will let you know if you reach the \$2,000 limit. Many people do not reach it in a year. At the start of each new calendar year, the amount of money you have paid in your Initial Coverage Stage will reset to zero.

Section E Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of \$2,000 for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

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

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

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects).
- If your doctor agrees, you will not have to pay for the full month's supply for certain drugs.

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

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is a little less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment will be a little less than \$0.05 per day multiplied by 7 days, for a total payment less than \$0.35.
- Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- You can also ask your provider to prescribe less than a full month's supply of a drug, if this will help you :
 - better plan when to refill your drugs,
 - coordinate refills with other drugs you take, **and**
 - take fewer trips to the pharmacy

Section G Vaccinations

Important message about what you pay for vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's **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 G1 What you need to know before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies are pharmacies that have agreed to work with our plan. A network provider is a provider who works with the health plan. A network provider should work with UnitedHealthcare Connected® for MyCare Ohio to ensure that you do not have any upfront costs for a Part D vaccine.

Section G2 What you pay for a vaccination

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- 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, Immunizations.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's **Drug List**. You may have to pay a copay for Medicare Part D vaccines. If the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP) then the vaccine will cost you nothing.

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

1. You get the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
 - For most adult Part D vaccines, you will pay nothing.
 - For other Part D vaccines, you will pay nothing or a copay.
 - Some states do not allow pharmacies to give shots.
2. You get the Medicare Part D vaccine at your doctor's office and the doctor gives you the shot.
 - You will pay nothing to the doctor for the vaccine.
 - Our plan will pay 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 itself at a pharmacy and 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 will pay a copay for the vaccine.
 - Our plan will pay for the cost of giving you the shot.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **[UHCCommunityPlan.com](https://www.uhccommunityplan.com)**.

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 the **Member Handbook**.

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

Section A Asking us to pay for your services or drugs

Except for any drug copays you owe, you should not get a bill for in-network services or drugs. Our network providers must bill the plan for the services and drugs you already got. A network provider is a provider who works with the health plan.

If you get a bill for the full cost of health care or drugs, except for bills for any drug copays you owe, call Member Services or send the bill to us. To send us a bill, refer to Chapter 2, Section A.

- If you have not paid the bill, we will pay the provider directly if the services or drugs are covered and you followed all the rules in the **Member Handbook**.
- If you have paid more than your share of the cost, the services or drugs are covered, and you followed all the rules in the **Member Handbook**, it is your right to be paid back.
- If the services or drugs are **not** covered, we will tell you.

Contact Member Services if you have any questions. If you get a bill for drug copays that you think you do not owe, or if you get a bill and you do not 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 some examples of times when you may need to ask our plan to assist you with a payment you made or a bill you got:

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

You should always tell the provider you are a member of UnitedHealthcare Connected® for MyCare Ohio and ask the provider to bill the plan.

- If you pay the full amount when you get the care, you can ask to have the full amount refunded. 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 do not 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 have already paid for the service, we will work with the provider to refund your payment except for any drug copays you owe.

2. When a network provider sends you a bill

Network providers must always bill the plan for covered services. Show your UnitedHealthcare Connected® for MyCare Ohio Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills.**



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- Because UnitedHealthcare Connected® for MyCare Ohio pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- We do not allow providers to add separate charges, called “balance billing.” This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you still do not have to pay them.
- 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 have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will work with the provider to refund your payment amount for your covered services except for any drug copays you owe.

3. When you use an out-of-network pharmacy to get a prescription filled in an emergency situation

- We will cover prescriptions filled at out-of-network pharmacies in emergency situations only. If you go to an out-of-network pharmacy and try to use your member ID to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations.) If you have already paid the pharmacy bill, please call Member Services. They will help you ask to be paid back for the out-of-pocket cost. You will need to send us the bill and proof of any payment you made. We will work with the pharmacy to refund your payment amount for your covered services except for any drug co-pays you owe.

Examples are:

- Prescriptions for a Medical Emergency

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

- Coverage when traveling or out of the service area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our network 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 have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- If you are traveling within the United States and become ill or run out of or lose your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules.
- If you are 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.
- During a declared disaster, if you get a prescription filled at an out-of-network pharmacy, please call us so we can help you obtain reimbursement for any out of pocket expense you might have incurred, excluding any applicable copay.
- If you are trying to fill a prescription drug not regularly stocked at a network retail or network preferred 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.

You can always contact Member Services at **1-877-542-9236** (TTY **711**) if you are being asked to pay for services, get a bill, or have any questions. You can use the form in this **Member Handbook** or ask Member Services to send you a form if you want to send us the information about the bill. You can also submit the information through our website at **UHCCommunityPlan.com**.

Section B How to avoid payment problems

1. Always ask the provider if the service is covered by UnitedHealthcare Connected® for MyCare Ohio.

Except in an emergency or urgent situation, do not agree to pay for a service unless you have asked UnitedHealthcare Connected® for MyCare Ohio for a coverage decision (refer to Chapter 9, Section E2), got a final decision that the service is not covered, and decided that you still want the service even though the plan does not cover it.

2. Get plan approval before going to an out-of-network provider.

- Exceptions to this rule are:
 - if you need out-of-network emergency or urgent care services, or
 - if you get services at Federally Qualified Health Centers, Rural Health Clinics, qualified family planning providers listed in **the Provider and Pharmacy Directory**.
- If you get care from an out-of-network provider, ask the provider to bill UnitedHealthcare Connected® for MyCare Ohio.

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- If the out-of-network provider is approved by UnitedHealthcare Connected® for MyCare Ohio, you should not have to pay anything.
- If the out-of-network provider will not bill UnitedHealthcare Connected® for MyCare Ohio and you pay for the service, call Member Services as soon as possible to let us know.
- Please remember that in most situations you must get plan approval before you can use an out-of-network provider. Therefore, unless you need emergency or urgent care, are in your transition of care period, or the provider does not require prior approval (PA) as indicated above, we may not pay for services you get from an out-of-network provider.

If you have questions about your transition of care period, whether you need approval to use a certain provider, or need help in finding a network provider, call Member Services.

If you get care from an out-of-network provider, ask the provider to bill UnitedHealthcare Connected® for MyCare Ohio. If the out-of-network provider is approved by UnitedHealthcare Connected® for MyCare Ohio, you should not have to pay anything. If the out-of-network provider will not bill UnitedHealthcare Connected® for MyCare Ohio and you pay for the service, call Member Services as soon as possible to let us know.

3. Follow the rules in the Member Handbook when getting services.

Refer to Chapter 3, Section B, for the rules about getting your health care, behavioral health, and other services. Refer to Chapter 5, Introduction, for the rules about getting your outpatient prescription drugs.

4. Use the Provider and Pharmacy Directory to find network providers.

If you do not have a **Provider and Pharmacy Directory**, you can call Member Services to ask for a copy or go online at **UHCCommunityPlan.com** for the most up-to-date information.

5. Always carry your member ID card and show it to the provider or pharmacy when getting care.

If you forgot your member ID card, ask the provider to call the plan or look up your information on our provider website. If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Chapter 8

Your rights and responsibilities

Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

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Section A Legal notices

Section A1 Notices 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 this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs and state laws about the Medicaid program. Other federal and state laws may apply too.

Section A2 Notice about non-discrimination

You have the right to be treated with respect, fairness and dignity at all times. Every company or agency that works with Medicare and Medicaid must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, gender identity, sexual orientation, genetic information, geographic location within the service area, health status, or need for health services in the receipt of health services, medical history, mental or physical disability, national origin, race, religion, sex, military status, or ancestry.

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.
- Call your local Office for Civil Rights.
 - **1-866-227-6353**
 - (TTY **1-866-221-6700**)

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.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit UHCCommunityPlan.com.

Civil Rights Notice

Discrimination is against the law. UnitedHealthcare Community Plan of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of any of the following:

- Race
- Color
- National origin
- Military Status
- Religion
- Genetic information
- Age
- Disability (including physical or mental impairment)
- Ancestry
- Political beliefs
- Public assistance status
- Medical condition
- Sex (including sex stereotypes and gender identity)
- Sexual orientation
- Health status (including the need for health services)

UnitedHealthcare Community Plan of Ohio provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

UnitedHealthcare Community Plan of Ohio provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call Member Services using the toll-free number on your member identification card.

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by **UnitedHealthcare Community Plan of Ohio**. 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, UT 84130
Email: **UHC_Civil_Rights@uhc.com**

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

Online: **<https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>**

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

By phone: **1-800-368-1019** (TDD: **1-800-537-7697**)

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. If you need help, please call the toll-free number on your member identification card.

Spanish: ATENCIÓN: Si habla español, los servicios de asistencia de idiomas están disponibles para usted sin cargo. Si necesita ayuda, llame al número de teléfono gratuito que aparece en su tarjeta de identificación de miembro.

Ukrainian: УВАГА! Якщо ви говорите українською мовою, ви можете скористатися безкоштовними послугами перекладача. Якщо вам потрібна допомога, зателефонуйте за безкоштовним номером, вказаним у вашій ідентифікаційній картці учасника.

Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Si ou bezwen èd, tanpri rele nimewo gratis lan ki sou kat idantifikasyon ou kòm manm lan.

Nepali: ध्यान दिनुहोस: तपाईं नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन्। कृपया तपाईंलाई मद्दत चाहिएमा तपाईंको सदस्यता परिचय कार्डमा भएको टोल-फ्री नम्बरमा फोन गर्नुहोस्।

Arabic: تنبيه: إذا كنت تتحدث العربية، فتتوفر لك خدمات المساعدة اللغوية مجاناً. اتصل على الرقم المجاني أعلاه. إذا كنت بحاجة إلى مساعدة، يُرجى الاتصال بالرقم المجاني المدون على بطاقة تعريف العضو الخاصة بك.

Russian: Внимание! Если Вы говорите по-русски, Вы можете бесплатно воспользоваться помощью переводчика. Если Вам нужна помощь, позвоните по номеру телефона для бесплатных звонков, указанному на Вашей идентификационной карточке участника.

Somali: OGSOONOW: Haddii aad ku hadasho Soomaali, adeegyada kaalmada luuqadda, oo bilaash ah, ayaad heli kartaa. Haddii aad u baahan tahay caawimaad, fadlan wac lambarka sida bilaashka loo waco ee ku yaala kaarkaaga aqoonsiga xubinnimo.

French: ATTENTION : si vous parlez français, vous pouvez obtenir une assistance linguistique gratuite. Si vous avez besoin d'aide, veuillez composer le numéro gratuit figurant sur votre carte de membre.

Kinyarwanda (Burundi): ICYITONDERWA: Niba uvuga Ikiyarwanda, serivisi z'ubufasha mu by'indimi zirahari ku buntu. Niba ukeneye ubufasha, hamagara nimero itishyurwa iri ku karita yawe iranga umunyamuryango.

Swahili: TAZAMA: : Ikiwa unasungumza Kiswahili, huduma za usaidizi kuhusu lugha, bila malipo, zinapatikana kwa ajili yako. Ikiwa unahitaji msada, tafadhali piga simu bila malipo kwa nambari iliyo kwenye kitambulisho chako cha mshiriki.

Uzbek: DIQQAT: Agar ingliz tilida so'zlasangiz, til masalasida yordam beradigan bepul xizmatlar mavjud. Agar yordam zarur bo'lsa, a'zo identifikatsiya kartasidagi bepul raqamga telefon qiling.

Pashto: پاملرنه: که تاسو په پښتو ژبه خبرې کوئ، د ژبې د مرستې خدمتونه، په وړیا توګه، تاسو لپاره شتون لري. که تاسو مرستې ته اړتیا لرئ، مهرباني وکړئ خپل د غړی پیژندنې کارت کې ورکړل شوې وړیا شمیرې ته زنگ ووهئ.

Turkish: DİKKAT: İngilizce konuşuyorsanız, size ücretsiz dil yardımı hizmetleri sunulabilir. Yardıma ihtiyaç duyarsanız, lütfen üye kimlik kartınızdaki ücret telefon numarasını arayın.

Dari: توجه: اگر شما به لسان دری صحبت میکنید، خدمات اسپستانت لسان به قسم رایگان در دسترس تان قرار میگیرد. اگر به کمک ضرورت پیدا کردید، لطفاً به نمبر رایگان مندرج در کارت هویت اعضا به تماس شوید.

Vietnamese: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Nếu quý vị cần trợ giúp, vui lòng gọi số miễn cước trên thẻ nhận dạng hội viên của quý vị.

Section A3 Notice about Medicare as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

Section B 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. Each year you are in our plan, we must also tell you about the plan's benefits and your rights in a way that you can understand.

You have the right to make recommendations regarding our member rights & responsibilities policy.

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

If you are having 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**.
- You can also contact the Ohio Medicaid Consumer Hotline at **1-800-324-8680**, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call **711**.
- Office of Civil Rights at **1-800-368-1019** or TTY **1-800-537-7697**.

Su derecho a recibir información de una manera que satisfaga sus necesidades

Cada año que usted esté inscrito en nuestro plan, debemos informarle sobre los beneficios del plan y sus derechos de una manera que usted pueda comprender.

Usted tiene derecho a hacer recomendaciones con respecto a nuestra norma sobre los derechos y responsabilidades de los miembros.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- Para obtener información de una manera que usted pueda comprender, llame a Servicio al Cliente. Nuestro plan cuenta con personas que pueden responder preguntas en diferentes idiomas.
- Nuestro plan también le puede proporcionar materiales en español y en otros formatos, como letra grande, braille o audio. Llame a Servicio al Cliente y pida que se anote en nuestro sistema que desea recibir los materiales del plan en español, letra grande, braille o audio a partir de ahora.
- Si tiene alguna dificultad para obtener información de nuestro plan debido a problemas de idioma o una discapacidad y desea presentar una queja, llame a Medicare al **1-800-MEDICARE (1-800-633-4227)**. Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al **1-877-486-2048**. También puede comunicarse con la Línea Directa de Ohio Medicaid al **1-800-324-8680**, de lunes a viernes, de 7 a.m. a 8 p.m., y los sábados, de 8 a.m. a 5 p.m. Los usuarios de TTY deben llamar al **7-1-1**.

Section C Our responsibility to ensure that you get timely access to covered services and drugs

As a member of our plan:

- You have the right to get all services that UnitedHealthcare Connected® for MyCare Ohio must provide and to choose the provider that gives you care whenever possible and appropriate.
- You have the right to be sure that others cannot hear or find you when you are getting medical care.
- You have the right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan. You can find more information about choosing a PCP in Chapter 3.
 - Call Member Services or look in the **Provider and Pharmacy Directory** to learn more about network providers and which doctors are accepting new patients.
- You have the right to use a network women's health specialist for covered women's health services without getting a referral. A referral is approval from your PCP to use someone 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 have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
- If you cannot get services within a reasonable amount of time, we have to 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.

Chapter 9 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care. Chapter 9 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

Section D Our responsibility to protect your personal health information (PHI) and your right to privacy

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

- Your personal health information includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.
- You have the right to be ensured of confidential handling of information concerning your diagnoses, treatments, prognoses, and medical and social history.
- You have rights related to your information and to control how your PHI is used. We give you a written notice that tells about these rights. The notice is called the “Notice of Privacy Practice.” The notice also explains how we protect the privacy of your PHI.

Section D1 How we protect your PHI

You have the right to be given information about your health. This information may also be available to someone who you have legally authorized to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.

We make sure that unauthorized people do not find or change your records.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Except for 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 are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you. There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.

- We are required to release PHI to government agencies that are checking on our quality of care.
- We are required to give Medicare PHI. If Medicare releases your PHI for research or other uses, it will be done according to Federal laws. We are also required to share your medical records with Medicaid.

Section D2 You have a 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 if it isn't to transfer the records to a new provider.

You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know if and how your PHI has been shared with others.

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **[UHCCommunityPlan.com](https://www.uhccommunityplan.com)**.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

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

Effective January 1, 2025

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

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com**.

- **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.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **[UHCCommunityPlan.com](https://www.uhccommunityplan.com)**.

- **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.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **[UHCCommunityPlan.com](https://www.uhccommunityplan.com)**.

- **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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- **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.

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCommunityPlan.com**.

FINANCIAL INFORMATION PRIVACY NOTICE

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

Effective January 1, 2025

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

Information We Collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and Security

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

Questions About This Notice

Please **call the toll-free member phone number on health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-866-842-4968**, or TTY/RTT **711**.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

²For 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>.

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section E Our responsibility to give you information about the plan, its network providers, and your covered services

As a member of UnitedHealthcare Connected® for MyCare Ohio, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at **1-877-542-9236** (TTY **711**). This is a free service. We have written materials in Spanish. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including but not limited to:
 - Financial information
 - How the plan has been rated by plan members
 - The number of appeals made by members
 - How to leave the plan
- Our network providers and our network pharmacies, including:
 - How to choose or change primary care providers (PCP). You can change your PCP to another network PCP monthly. We must send you something in writing that says who the new PCP is and the date the change began.
 - Qualifications of our network providers and pharmacies
 - How we pay providers in our network
 - A list of providers and pharmacies in the plan’s network, are in the **Provider and Pharmacy Directory**. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at **UHCCommunityPlan.com**.
- Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) and about rules you must follow, including:
 - Services and drugs covered by the plan
 - Limits to your coverage 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), including asking us to:

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- Put in writing why something is not covered
- Change a decision we made
- Pay for a bill you got

Section F 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 charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, refer to Chapter 7.

Section G Your right to get your Medicare and Part D coverage from Original Medicare or another Medicare plan at any time by asking for a change

- You have the right to get your Medicare health care services through Original Medicare or a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- Refer to Chapter 10 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- You must continue to get your Medicaid services from a MyCare Ohio plan.

If you want to make a change, you can call the Ohio Medicaid Hotline at **1-800-324-8680** (TTY users should call **711**), Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. Calls to this number are free.

Section H Your right to make decisions about your health care

Section H1 Your right to know your treatment options and make decisions about your health care

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

- **Know your choices** and be told about all the kinds of treatment provided in a way appropriate to your condition and ability to understand regardless of cost or benefit coverage.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- **Know the risks** and be told about any risks involved.
 - You must be told 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** by using another qualified network provider before deciding on treatment.
 - If a qualified network provider is not able to see you, we will arrange a visit with a non-network provider at no cost to you.
- **Say “no”** and refuse any treatment or therapy.
 - This includes the right to:
 - leave a hospital or other medical facility, even if your doctor advises you not to.
 - stop taking a drug.
 - If you say no to treatment, therapy or taking a drug, the doctor or UnitedHealthcare Connected® for MyCare Ohio must talk to you about what could happen and they must put a note in your medical record.
 - If you refuse treatment or stop taking a drug, you will not be dropped from the 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** and get an explanation from us if a provider has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9 tells how to ask the plan for a coverage decision.
- **Know of specific student practitioner roles** and refuse treatment from a student.

Section H2 **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 to **give 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.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid may also have advance directive forms. The forms are also currently available on the following website: **proseniors.org/advance-directives**.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital.**

The hospital will ask you whether you have signed an advance directive form and whether you have it with you.

If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

Section H3 What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Ohio Department of Health by calling **1-800-342-0553** or emailing **HCComplaints@odh.ohio.gov**.

ADVANCE DIRECTIVES

You Have the Right

Using Advance Directives to State Your Wishes About Your Medical Care

People often worry about the medical care they would get if they became too sick to make their wishes known.

Some people may not want to spend months or years on life support. Others may want every step taken to lengthen life.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

You can state your medical care wishes in writing while you are healthy and able to choose. Your health care facility must explain your right to state your wishes about medical care. It also must ask you if you have put your wishes in writing.

This document explains your rights under Ohio law to accept or refuse medical care. The document also explains how you can state your wishes about the care you would want if you could not choose for yourself. This document does not contain legal advice, but will help you understand your rights under the law.

What are my rights to choose my medical care?

You have the right to choose your own medical care. If you do not want a certain type of care, you have the right to tell your doctor you do not want it.

What if I'm too sick to decide? What if I cannot make my wishes known?

Most people can make their wishes about their medical care known to their doctors. But, some people become too sick to tell their doctors about the type of care they want. Under Ohio law, you have the right to fill out a form while you are able to act for yourself. The form tells your doctors what you want done if you can't make your wishes known.

What kinds of forms are there?

Under Ohio law, there are four different forms, or advance directives, you can use: a Living Will, a Do Not Resuscitate (DNR) Order, a Health Care Power of Attorney (also known as a Durable Power of Attorney for Health Care) and a Declaration for Mental Health Treatment. You fill out an advance directive while you are able to act for yourself. The advance directive lets your doctor and others know your wishes about medical care.

Do I have to fill out an advance directive before I get medical care?

No. No one can make you fill out an advance directive. You decide if you want to fill one out.

Who can fill out an advance directive?

Anyone 18 years old or older who is of sound mind and can make his or her own decisions can fill one out.

Do I need a lawyer?

No, you don't need a lawyer to fill out an advance directive.

Do the people giving me medical care have to follow my wishes?



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). For more information, visit **UHCCommunityPlan.com**.**

Yes, if your wishes follow state law. However, a person giving you medical care may not be able to follow your wishes because they go against his or her conscience. If so, they will help you find someone else who will follow your wishes.

Living Will

A Living Will states how much you want to use life-support methods to lengthen your life. It takes effect only when you are:

- In a coma that is not expected to end, –OR–
- Beyond medical help with no hope of getting better and can't make your wishes known, –OR–
- Expected to die and are not able to make your wishes known.

The people giving you medical care must do what you say in your Living Will. A Living Will gives them the right to follow your wishes. Only you can change or cancel your Living Will. You can do so at any time.

Do Not Resuscitate Order

A Do Not Resuscitate (DNR) Order is an order written by a doctor or, under certain circumstances, a certified nurse practitioner or clinical nurse specialist, that instructs health care providers not to do cardiopulmonary resuscitation (CPR). In Ohio, there are two types of DNR Orders: (1) DNR Comfort Care, and (2) DNR Comfort Care–Arrest. You should talk to your doctor about DNR options.

Health Care Power of Attorney

A Health Care Power of Attorney is different from other types of powers of attorney. This document talks only about a Health Care Power of Attorney, not about other types of powers of attorney.

A Health Care Power of Attorney allows you to choose someone to carry out your wishes for your medical care. The person acts for you if you cannot act for yourself. This could be for a short time period or for a long time period.

Who should I choose?

You can choose any adult relative or friend whom you trust to act for you when you cannot act for yourself. Be sure to talk with the person about what you want. Then write down what you do or do not want. You should also talk to your doctor about what you want. The person you choose must follow your wishes.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

When does my Health Care Power of Attorney take effect?

The form takes effect only when you can't choose your care for yourself. The form allows your relative or friend to stop life support only in the following circumstances:

- If you are in a coma that is not expected to end, –OR–
- If you are expected to die.

Declaration for Mental Health Treatment

A Declaration for Mental Health Treatment gives more specific attention to mental health care. It allows you, while capable, to appoint a representative to make decisions on your behalf when you lack the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment. For example, you can indicate medication and treatment preferences, and preferences concerning admission/retention in a facility.

What is the difference between a Health Care Power of Attorney and a Living Will?

Your Living Will explains, in writing, your wishes about the use of life-support methods if you are unable to make your wishes known. Your Health Care Power of Attorney lets you choose someone to carry out your wishes for medical care when you cannot act for yourself.

If I have a Health Care Power of Attorney, do I need a Living Will, too?

You may want both. Each addresses different parts of your medical care.

Can I change my advance directives?

Yes, you can change your advance directives whenever you want. It is a good idea to look over your advance directives from time to time to make sure they still say what you want and that they cover all areas.

If I don't have an advance directive, who chooses my medical care when I can't?

Ohio law allows your next-of-kin to choose your medical care if you are expected to die and cannot act for yourself.

Where do I get advance directive forms?

Many of the people and places that give you medical care have advance directive forms. You may also be able to get these forms at JFS 7236 R&R.indd (ohio.gov).



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

What do I do with my forms after filling them out?

You should give copies to your doctor and health care facility to put into your medical record. Give one to a trusted family member or friend. If you have chosen someone in a Health Care Power of Attorney, give that person a copy. Put a copy with your personal papers. You may want to give one to your lawyer or clergy person. Be sure to tell your family and friends about what you have done. Do not just put these forms away and forget about them.

Organ and Tissue Donation

Ohioans can choose whether they would like their organs and tissues to be donated to others in the event of their death. By making their preference known, they can ensure that their wishes will be carried out immediately and that their families and loved ones will not have the burden of making this decision at an already difficult time. Some examples of organs that can be donated are the heart, lungs, liver, kidneys and pancreas. Some examples of tissues that can be donated are skin, bone, ligaments, veins and eyes.

There are two ways to register to become an organ and tissue donor:

- (1) You can state your wishes for organ and/or tissue donation when you obtain or renew your Ohio Driver License or State I.D. Card, –OR–
- (2) You may register online for organ donation through the Ohio Donor Registry website: donatelifeohio.org.

Section I Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9 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 us to change a coverage decision, or make a complaint. We will also send you a notice when you can make an appeal directly to the Bureau of State Hearings within the Ohio Department of Job and Family Services.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section I1 **What to do if you believe you are being treated unfairly or you would like more information about your rights**

You are free to exercise all of your rights knowing that UnitedHealthcare Connected® for MyCare Ohio, our network providers, Medicare, and the Ohio Department of Medicaid will not hold it against you.

If you believe you have been treated unfairly — and it is **not** about discrimination for the reasons listed in Chapter 11 or you would like more information about your rights, you can get help by calling:

- Member Services.
- The Ohio Medicaid Consumer Hotline at **1-800-324-8680** (TTY users call **7-1-1**), Monday–Friday from 7 a.m.–8 p.m. and Saturday from 8 a.m.–5 p.m. Calls to this number are free.
- 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](https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf).)
- The MyCare Ohio Ombudsman in the Office of the State Long-Term Care Ombudsman at **1-800-282-1206**, Monday–Friday from 8 a.m.–5 p.m. Refer to Chapter 2 for more information about this organization.

Section J **Your responsibilities as a member of the plan**

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

- **Read the Member Handbook** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:
 - Covered services, refer to Chapters 3 and 4. 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.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure that you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.
- **Tell your doctor and other health care** providers that you are enrolled in our plan. Show your Member ID Card whenever you get services or drugs.

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- **Help your doctors** and other health care providers give you the best care.
 - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
 - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
 - 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 our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - Medicare Part A and Medicare Part B premiums. For nearly all UnitedHealthcare Connected® for MyCare Ohio members, Medicaid pays the Part A premium and Part B premium. If you pay your Part A and/or part B premium and think Medicaid should have paid, you can contact your County Department of Job and Family Services and ask for assistance.
 - For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug.

If you get any services or drugs that are not covered by our plan, you may have to pay for the service or drug.

- 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 are going 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 this plan.** Only people who live in our service area can get UnitedHealthcare Connected® for MyCare Ohio. Chapter 1 tells about our service area.
 - We can help you figure out whether you are moving outside our service area. We can let you know if we have a plan in your new area.
 - Also, be sure to let Medicare and Medicaid know your new address when you move. Refer to Chapter 2 for phone numbers for Medicare and Medicaid.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com**.

- **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you. Refer to Section K in Chapter 1 for more information. You must also notify your County Caseworker at the local Department of Job and Family Services.

- Call Member Services for help if you have questions or concerns.

Section J1 Estate recovery program

If you are permanently institutionalized or age 55 or older when you get Medicaid benefits, the Estate Recovery Program may recover payments from your estate for the cost of your care paid by the Ohio Department of Medicaid. The cost of your care may include the capitation payment that the Ohio Department of Medicaid pays to your managed care plan, even if the payment is greater than the cost of the services you got. Estate recovery happens after your death.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com**.

Chapter 9

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

Introduction

This chapter has information about your rights to ask for a coverage decision, an appeal or make a complaint. 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 has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

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

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

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. However, sometimes you may run into a problem getting services, or you may be unhappy with how services were provided or how you were treated. This chapter explains the different options you have for dealing with problems and complaints about our plan, our plan's providers, getting services, and payment of services. **You can also call the MyCare Ohio Ombudsman at 1-800-282-1206 to help guide you through your problem.**

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at 1-877-542-9236 (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). For more information, visit [UHCCommunityPlan.com](https://www.uhccommunityplan.com).

Chapter 9

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

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). For more information, visit **UHCCommunityPlan.com**.

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section A What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section A1 About the legal terms

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

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

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

Section B Where to call for help

Section B1 Where to get 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 knowledge you need to take the next step. You can contact any of the following resources for help.

Getting help from UnitedHealthcare Connected® for MyCare Ohio’s Member Services

Member Services can help you with any problems or complaints about your health care, drugs, and long-term services and supports. We want to help with problems such as: understanding what services are covered; how to get services; finding a provider; being asked to pay for a service; asking for a coverage decision or appeal; or making a complaint (also called a grievance). To contact us you can:

- Call Member Services at **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). The call is free.

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- Visit our website at **UHCCommunityPlan.com** to send a question, complaint, or appeal.
- Fill out the appeal/complaint form of this chapter or call Member Services and ask us to mail you a form.
- Write a letter telling us about your question, problem, complaint, or appeal. Be sure to include your first and last name, the number from the front of your UnitedHealthcare Connected® for MyCare Ohio Member ID Card, and your address and telephone number. You should also send any information that helps explain your problem.

Mail the form or your letter to:

Grievances and Medical (Non-Drug) Appeals:
UnitedHealthcare Community Plan
Attn: Complaint and Appeals Department
PO Box 6103
MS CA120-0360
Cypress, CA 90630
Standard Fax: **801-994-1394**
Expedited Fax: **1-866-373-1081**

Drug (Part D) Appeals:
UnitedHealthcare Community Plan
Attn: Part D Standard Appeals
P.O. Box 6103
MS CA120-0368
Cypress, CA 90630
Standard Fax: **877-960-8235**
Expedited Fax: **801-994-1082**

Getting help from the Ohio Department of Medicaid

If you need help, you can always call the Ohio Medicaid Consumer Hotline. The hotline can answer your questions and direct you to staff that will help you understand what to do about your problem. The hotline is not connected with us or with any insurance company or health plan. You can call the Ohio Medicaid Consumer Hotline at **1-800-324-8680** (TTY: **711**), Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. The call is free. You can also visit the Ohio Department of Medicaid website at **medicaid.ohio.gov**.

Getting help from the MyCare Ohio Ombudsman

You can also get help from the MyCare Ohio Ombudsman. The MyCare Ohio Ombudsman is an ombudsman program that can help you resolve issues that you might have with our plan. They can help you file a complaint or an appeal with our plan. Refer to Chapter 2, section H for more information on ombudsman programs.

The MyCare Ohio Ombudsman is an independent advocate and is not connected with us or with any insurance company or health plan. You can call the MyCare Ohio Ombudsman at **1-800-282-1206** (TTY Ohio Relay Service: **1-800-750-0750**), Monday through Friday from 8:00 am to 5:00 pm. You can also submit an online complaint at: **aging.ohio.gov/contact**. The services are free.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Getting help from Medicare

You can call Medicare directly for help with problems. 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: **1-877-486-2048**. The call is free.
- Visit the Medicare website at **medicare.gov**.

Getting help from other resources

You may also want to talk to the following people about your problem and ask for their help.

- You can talk to your doctor or other provider. Your doctor or other provider can ask for a coverage decision. If you disagree with the coverage decision, the doctor or other provider that requested the service can submit a Level 1 appeal on your behalf (refer to Section E3 to learn more about Level 1 appeals).
 - If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only or for a Medicaid State Hearing, you must name them as your representative in writing.
- You can talk to a friend or family member. A friend or family member can ask for a coverage decision, an appeal, or submit a complaint on your behalf if you name them as your “representative.”
 - If you want someone to be your representative, including your doctor or provider, with your consent, call Member Services and ask for the “Appointment of Representative” form. You can also get the form by visiting **cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms** or on our website at **UHCCommunityPlan.com**. The form gives the person permission to act for you. You must give us a copy of the signed form.
 - We will also accept a letter or other appropriate form to authorize your representative.
- You can talk to a lawyer. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. If you want information on free legal help, you can contact your local legal aid office or call Ohio Legal Aid toll-free at **1-866-529-6446 (1-866-LAW-OHIO)**. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form. Please note, **you do not need a lawyer** to ask for a coverage decision or to make an appeal or complaint.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section C Problems with your benefits

Section C1 Using the process for coverage decisions and appeals or for making a complaint

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

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, and/or long-term services and supports) are covered or not, the way in which they are covered, and problems related to payment for medical care.)

Yes. My problem is about benefits or coverage.

Refer to **Section D: “Coverage decisions and appeals”**.

No. My problem is not about benefits or coverage.

Skip ahead to **Section J: “How to make a complaint”**.

Section D Coverage decisions and appeals

Section D1 Overview of coverage decisions and appeals

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

What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medicaid, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at 1-877-542-9236 (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). For more information, visit UHCCommunityPlan.com.

What is an appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not medically necessary, not a covered benefit, or is no longer covered by Medicare or Medicaid. If you or your doctor disagree with our decision, you can appeal.

How can I get help with coverage decisions and appeals?

If you need help, you can contact any of the resources listed in **Section B1**.

Section D2 Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section E** gives you information if you have problems getting medical care (but **not** Part D drugs). For example, use this section if:
 - You are not getting medical care you want, and you believe our plan covers this care.
 - We did not approve medical care that your doctor wants to give you, and you believe this care should be covered.
 - **NOTE:** Only use **Section E** for problems with drugs **not** covered by Part D. Drugs in the **List of Covered Drugs**, also known as the **Drug List**, with an asterisk (*) are **not** covered by Part D. Refer to **Section F** for Part D drug appeals.
 - You got medical care you think should be covered, but we are not paying for this care.
 - You got and paid for medical care you thought we cover, and you want to ask us to pay for the services so your payment can be refunded.
 - You are being told that coverage for medical care you have been getting will be reduced or stopped, and you disagree with our decision.
 - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Refer to **Sections G** and **H**.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why, and how to ask for a review of the dismissal. This review is a formal process called an appeal.
- **Section F** gives you information if you have problems about Part D drugs. For example, use this section if:
 - You want to ask us to make an exception to cover a Part D drug that is not on our **Drug List**.
 - You want to ask us to waive limits on the amount of the drug you can get.
 - You want to ask us to cover a drug that requires prior approval (PA).
 - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
 - You want to ask us to pay for a prescription drug you already bought so your payment can be refunded. (This is asking for a coverage decision about payment.)
- **Section G** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
 - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section H** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Member Services at **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week).

If you need other help or information, please call the MyCare Ohio Ombudsman at **1-800-282-1206** (TTY Ohio Relay Service: **1-800-750-0750**).



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section E Problems about medical care

Section E1 When to use this section

This section is about what to do if you have problems with your benefits for your medical care such as medical services or items, dental or vision services, behavioral health services, and long-term services and supports. You can also use this section for problems with drugs that are **not** covered by Part D, including Medicare Part B drugs. Drugs in the **Drug List** with an * are not covered by Part D. Use **Section F** for Part D drug appeals.

This section tells what you can do if you are in any of the 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 E2** for information on asking for a coverage decision.

2. You want us to cover a benefit that requires plan approval (also called prior authorization (PA)) before you get the service.

What you can do: You can ask us to make a coverage decision. Refer to **Section E2** for information on asking for a coverage decision.

NOTE: Refer to the Benefits Chart in Chapter 4 for a general list of covered services as well as information on what services require PA from our plan. Refer to the **Drug List** to find out if any drugs require PA. You can also find the lists of services and drugs that require PA at **UHCCommunityPlan.com**.

3. We did not approve medical care your doctor wants to give you, and you think we should have.

What you can do: You can appeal our decision to not approve the care. Refer to **Section E3** for information on making an appeal.

4. We did not approve your request to get waiver services from a specific network non-agency or participant-directed provider.

What you can do: You can appeal our decision to not approve the request. Refer to **Section E3** for information on making an appeal.

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

What you can do: You can appeal our decision not to pay. Refer to **Section E3** for information on making an appeal.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

6. You got and paid for medical care you thought were covered, and you want us to work with the provider to refund your payment.

What you can do: You can ask us to work with the provider to refund your payment. Refer to **Section E5** of this section for information on asking for payment.

7. We reduced, suspended, or stopped your coverage for medical care, and you disagree with our decision.

What you can do: You can appeal our decision to reduce, suspend, or stop the service or item. Refer to **Section E3** for information on making an appeal.

NOTE: If we tell you that previously approved services or items will be reduced, suspended, or stopped before you receive all of the services or items that were approved, you may be able to continue to get the services and items during the appeal. Read “Will my benefits continue during Level 1 appeals”.

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read **Sections G or H** to find out more.

8. We did not make a coverage decision within the timeframes we should have.

What you can do: You can file a complaint or an appeal. Refer to **Section J** for information on making a complaint. Refer to **Section E3** for information on making a Level 1 Appeal.

NOTE: If you need help deciding which process to use, you can call the MyCare Ohio Ombudsman at **1-800-282-1206** (TTY Ohio Relay Service: **1-800-750-0750**).

9. We did not make an appeal decision within the timeframes we should have

What you can do: You can file a complaint. Refer to **Section J** for information on making a complaint. Also, if your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing. Refer to **Section E4** for information on asking for a State Hearing. Note that if your problem is about coverage for a Medicare service or item, we will automatically forward your appeal to Level 2 if we do not give you an answer within the required timeframe.

NOTE: If you need help deciding which process to use, you can call the MyCare Ohio Ombudsman at **1-800-282-1206** (TTY Ohio Relay Service: **1-800-750-0750**).



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com**.

Section E2 Asking for a coverage decision

How to ask for a coverage decision to get a service, item, or Medicaid drug (refer to Section F for Medicare Part D drugs)

To ask for a coverage decision, call, write, or fax us, or ask your authorized representative or doctor to ask us for a decision.

- You can call us at: **1-877-542-9236** TTY: **711** (8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). Member Services also has free language interpreter services available for non-English speakers.
- You can fax us at: Standard Fax: **801-994-1394**, Expedited Fax: **1-866-373-1081**
- You can write to us at: UnitedHealthcare Community Plan Attn: Complaint and Appeals Department, PO Box 6103, MS CA120-0368, Cypress, CA 90630.

Remember, you must complete the Appointment of Representative form to appoint someone as your authorized representative. We will also accept a letter or other appropriate form to authorize your representative. For more information, refer to **Section B1**.

How long does it take to get a coverage decision?

We will make a standard coverage decision on Medicaid or Medicare Part B prescription drugs within 72 hours after we receive your request.

We will make a standard coverage decision on all other services and items within 10 calendar days after you asked. If we don't give you our decision within 10 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

You or your provider can ask for more time, or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 24 hours for Medicaid or Medicare Part B prescription drugs and within 72 hours for all other services and items.

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Except for fast coverage decisions for Medicaid drugs, you or your provider can ask for more time or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at **1-877-542-9236 (TTY 711)** (8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week) or fax us at Standard Fax: **844-226-0356**, Expedited Fax: **1-866-373-1081**. For details on how to contact us, refer to Chapter 2.
- You can also have your doctor or your authorized representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision **only if you are asking for coverage for medical items and/or services you have not yet received**. (You cannot ask for a fast coverage decision if your request is about payment for items or services you already got.)
2. You can get a fast coverage decision **only if the standard deadlines could cause serious harm to your health or hurt your ability to function**. The standard deadlines are 72 hours for Medicaid or Medicare Part B prescription drugs and 10 calendar days for all other services and items.
 - If your doctor says that you need a fast coverage decision, we will automatically give you one.
 - If you ask for a fast coverage decision without your doctor's support, we will decide if you get a fast coverage decision.
 - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard deadlines (72 hours for a Medicaid or Medicare Part B prescription drugs) instead to make our decision.
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell 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 the process for making complaints, including fast complaints, refer to **Section J**.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

Section E3 Level 1 Appeal for medical care (not Part D drugs)

What is an Appeal?

An appeal is a formal way of asking us to review our coverage decision and change it if you think we made a mistake. If you, your authorized representative, or your doctor or other provider disagree with our decision, you can appeal. You can also appeal our failure to make a coverage decision within the timeframes we should have. We will send you a notice in writing whenever we take an action or fail to take an action that you can appeal.

NOTE: If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only, you must name them as your representative in writing. Read “Can someone else make the appeal for me” for more information.

If you need help during the appeals process, you can call the MyCare Ohio Ombudsman at **1-800-282-1206** (TTY Ohio Relay Service: **1-800-750-0750**). The MyCare Ohio Ombudsman is not connected with us or with any insurance company or health plan.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to find out if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

How do I make a Level 1 Appeal?

- To start your appeal, you, your authorized representative, or your doctor or other provider must contact us. You can call us at **1-877-542-9236 (TTY 711)** 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week) or write to us at the following address:

UnitedHealthcare Community Plan
Attn: Complaint and Appeals Department
PO Box 6103
MS CA120-0360
Cypress, CA 90630

Fax-Expedited: **1-866-373-1081**

- If you decide to write to us, you can draft your own letter or you can use the appeal/complaint form. Be sure to include your first and last name, the number from the front of your UnitedHealthcare Connected® for MyCare Ohio Member ID Card, and your address and telephone number. You should also include any information that helps explain your problem.
- For additional details on how to reach us for appeals, refer to Chapter 2.
- You can ask us for a “standard appeal” or a “fast appeal.”

The legal term for “fast appeal” is “**expedited reconsideration.**”

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone else can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

If we don't get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com.**

To get an Appointment of Representative form, call Member Services and ask for one, or visit the Medicare website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at UHCCommunityPlan.com. We will also accept a letter or other appropriate form to authorize your representative.

If the appeal comes from someone besides you or your doctor or other provider that requested the service, we must get your written authorization before we can review the appeal. For services covered by Medicaid only, if you want your doctor, other provider, or anyone else to act on your behalf, we must get your written authorization.

How much time do I have to make an appeal?

You must ask for an appeal **within 65 calendar days** after the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal. You should explain the reason your appeal is late when you make your appeal.

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read “Will my benefits continue during Level 1 appeals” for more information.

Can I get a copy of my case file?

Yes. Ask us for a copy by calling Member Services at **1-877-542-9236 (TTY 711)** 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week).

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to find out if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a “standard” appeal decision?

We must give you our answer within 15 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your health condition requires us to.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit UHCCommunityPlan.com.

- However, if you or your provider asks for more time or if we need to gather more information, we may take up to 14 more calendar days. If we decide we need to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to **Section J**.
- If we do not give you an answer to your appeal within 15 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item (refer to **Section E4**). You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing (refer to **Section E4**).

You can also file a complaint about our failure to make an appeal decision within the required timeframe (refer to **Section J**).

At a glance: How to make a Level 1 Appeal

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 65 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing.

Keep reading this section to learn about what deadline applies to your appeal.

If our answer is Yes to part or all of what you asked for, we must approve the service within 15 calendar days after we get your appeal (or within 7 days after we get your appeal for a Medicare Part B prescription drug).

If our answer is 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 service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal (refer to **Section E4**). If your problem is about coverage of a Medicaid service or item, the letter will tell you that you can also request a State Hearing (refer to **Section E4**).



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

When will I hear about a “fast” appeal decision?

If you ask for a fast appeal, we will give you our answer within 72 hours after we get all information needed to decide your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you or your provider asks for more time or if we need to gather more information, we may take up to 14 more calendar days. If we take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to **Section J**.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item (refer to **Section E4**). You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing (refer to **Section E4**).

You can also file a complaint about our failure to make an appeal decision within the required timeframe (refer to **Section J**).

If our answer is Yes to part or all of what you asked for, we must authorize the coverage within 72 hours after we get your appeal.

If our answer is 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 service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal (refer to **Section E4**). If your problem is about coverage of a Medicaid service or item, the letter will tell you that you can also request a State Hearing (refer to **Section E4**).

Will my benefits continue during Level 1 appeals?

Yes, if you meet certain requirements. If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, we will send you a notice at least 15 days in advance of taking the action. You, your authorized representative, or your doctor or other provider must **ask for an appeal on or before the later of the following** to continue the service during the appeal:

- Within 15 calendar days of the mailing date of our notice of action; **or**
- The intended effective date of the action.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; or 2) 15 calendar days pass after we notify you that we said **No** to your appeal.

Note: Sometimes your benefits may continue even if we say **No** to your appeal. If the service is covered by Medicaid and you ask for a State Hearing, you may be able to continue your benefits until the Bureau of State Hearings makes a decision. If the service is covered by both Medicare and Medicaid, your benefits will continue during the Level 2 appeal process. For more information, refer to **Section E4**.

Section E4 Level 2 Appeal for medical care (not Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is primarily covered by Medicare and/or Medicaid.

- If your problem is about a **Medicaid** service or item, the letter will tell you that you may ask for a State Hearing. Refer to this section for information on State Hearings.
- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that could be primarily covered by **both Medicare and Medicaid**, you will automatically get a Level 2 Appeal with the IRE. The letter will tell you that you may also ask for a State Hearing. See below in this section for information on State Hearings.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal regarding a service or item. The Level 2 Appeal is reviewed by an independent organization that is not connected to the plan.

My problem is about a Medicaid service or item. How can I make a Level 2 Appeal?

If we say **No** to your Appeal at Level 1 and the service or item is usually covered by Medicaid, you may ask for a State Hearing.

What is a State Hearing?

A State Hearing is a meeting with you or your authorized representative, our plan, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). You will explain why you think our plan did not make the right decision and we will explain why we made our decision. The hearing officer will listen and then decide who is right based on the information given and the rules.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

We will send you a notice in writing of your right to request a State Hearing. If you are on the MyCare Ohio Waiver, you may have other State Hearing rights. Please refer to your Home & Community-Based Services Waiver **Member Handbook** for more information about your rights.

How do I ask for a State Hearing?

To ask for a State Hearing, you or your authorized representative must contact the Bureau of State Hearings **within 90 calendar days** of the date that we sent the notice of your State Hearing rights. The 90 calendar days begins on the day after the mailing date on the notice. If you miss the 90 calendar day deadline and have a good reason for missing it, the Bureau of State Hearings may give you more time to request a hearing. Remember, you have to ask for a Level 1 Appeal before you can ask for a State Hearing.

NOTE: If you want someone to act on your behalf, including your doctor or other provider, you must give the Bureau of State Hearings written notice saying that you want that person to be your authorized representative.

You can sign and send the State Hearing form to the address or fax number listed on the form or submit your request by e-mail to **bsh@jfs.ohio.gov**. You can also call the Bureau of State Hearings at **1-866-635-3748**.

How long does it take to get a State Hearing decision?

State Hearing decisions are usually given no later than 70 calendar days after the Bureau of State Hearings gets your request. However, if the Bureau of State Hearings agrees that this timeframe could cause serious harm to your health or hurt your ability to function, the decision will be given as quickly as needed, but no later than 3 working days after the Bureau of State Hearings gets your request.

My problem is about a service or item that is covered by Medicare. What will happen at the Level 2 Appeal?

If we say No to your Appeal at Level 1 and the service or item is usually covered by Medicare, you will automatically get a Level 2 Appeal from the Independent Review Entity (IRE). An Independent Review Entity (IRE) will carefully review the Level 1 decision and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week).



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

How long does it take to get an IRE decision?

- The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.
 - However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- If you had “fast appeal” at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.
 - However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

What if my service or item is covered by both Medicare and Medicaid?

If your problem is about a service or item that could be covered by both Medicare and Medicaid, we will automatically send your Level 2 Appeal to the Independent Review Entity. You can also ask for a State Hearing. To ask for a State hearing, follow the instructions in this section.

Will my benefits continue during Level 2 appeals?

If we decide to change or stop coverage for a service that was previously approved, *you can* ask to continue your benefits during Level 2 Appeals in some cases.

- If your problem is about a service primarily covered by **Medicaid only**, you can ask to continue your benefits during Level 2 appeals. You or your authorized representative must **ask for a State Hearing before the later of the following** to continue the service during the State Hearing:
 - Within 15 calendar days of the mailing date of our letter telling you that we denied your Level 1 appeal; **or**
 - The intended effective date of the action.
- If your problem is about a service primarily covered by **Medicare only**, your benefits for that service will **not** continue during the Level 2 appeal process with the Independent Review Entity (IRE).



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- If your problem is about a service primarily covered by **both Medicare and Medicaid**, your benefits for that service will automatically continue during the Level 2 appeal process with the IRE. If you also ask for a State Hearing, you can continue your benefits while the hearing is pending if you submit your request within the timeframes listed above.

If your benefits are continued, you can keep getting the service until one of the following happens: (1) you withdraw the appeal; (2) all entities that got your Level 2 Appeal (the IRE and/or Bureau of State Hearings) decide **No** to your request.

How will I find out about the decision?

If your Level 2 Appeal was a State Hearing, the Bureau of State Hearings will send you a written hearing decision in the mail.

- If the hearing decision is **Yes** (sustained) to all or part of what you asked for, the decision will clearly explain what our plan must do to address the issue. If you do not understand the decision or have a question about getting the service or payment being made, contact Member Services for assistance.
- If the hearing decision is **No** (overruled) to part or all of what you asked for, it means the Bureau of State Hearings agreed with the Level 1 decision. The State Hearing decision will explain the Bureau of State Hearings' reasons for saying No and will tell you that you have the right to request an Administrative Appeal.

If your Level 2 Appeal went to the Independent Review Entity (IRE), the Independent Review Entity (IRE) will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

I appealed to both the Independent Review Entity and the Bureau of State Hearings for services covered by both Medicare and Medicaid. What if they have different decisions?



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

If either the Independent Review Entity or the Bureau of State Hearings decides **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is No for all or part of what I asked for, can I make another appeal?

If your Level 2 Appeal was a State Hearing, you can appeal again by asking for an Administrative Appeal. The Bureau of State Hearings must get your request for an Administrative Appeal within 15 calendar days of the date the hearing decision was issued.

If your Level 2 Appeal went to the Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

Refer to **Section I** for more information on additional levels of appeal.

Section E5 **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. The only amount you should be asked to pay is the copay for Part D prescription drugs (refer to Chapter 6).

If you get a bill that is more than your copay for covered services and 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. It is possible that we will pay the provider so they can refund your payment or the provider will agree to stop billing you for the service.

For more information, start by reading Chapter 7: Asking us to pay a bill you have gotten for covered services or drugs. Chapter 7 describes the situations in which you may need to ask us to assist you with payment you made to a provider or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment. Chapter 7 also gives information to help you avoid payment problems in the future.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill that is more than your copay for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will find out if the service or item you paid for is a covered service or item, and we will check if you followed all the rules for using your coverage.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- If the service or item you paid for is covered and you followed all the rules, we will work with the provider to refund your payment except for any drug copays you owe.
- 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.

What if we say we will not pay?

If you do not agree with our decision, you can make an appeal. Follow the appeals process described in **Section E3**. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking to be paid back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should make payment, we must send the payment 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 the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. Refer to **Section I** for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicaid, you can request a State Hearing (refer to **Section E4**).



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section F Part D drugs

Section F1 What to do if you have problems getting a Part D drug or you want your payment refunded for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are “Part D drugs.” There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals.**

- The **Drug List** includes some drugs with an *. These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with an * follow the process in **Section E**.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
 - Asking us to cover a Part D drug that is not on the plan’s **Drug List**
 - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan’s **Drug List** but we require you to get approval from us before we will cover it for you).
 - **NOTE:** If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment. Remember, you should not have to pay for any medically necessary services covered by Medicare and Medicaid. If you are being asked to pay for the full cost of a drug, call Member Services for assistance.

The legal term for a coverage decision about your Part D drugs is “**coverage determination.**”

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

Use the chart below to help you decide which section has information for your situation:



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com**.

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with Section F2 . Also refer to Sections F3 and F4 .	You can ask us for a coverage decision. Skip ahead to Section F4 .	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to Section F4 .	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section F5 .

Section F2 What an exception is

An exception is permission to get coverage for a drug that is not normally on our **Drug List** or to use the drug without certain rules and limitations. If a drug is not on our **Drug List** or is not covered in the way you would like, you can ask us to make an “exception.”

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

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

1. Covering a Part D drug that is not on our **Drug List**.
 - If we agree to make an exception and cover a drug that is not on the **Drug List**, you will need to pay the cost-sharing amount that applies to all of our drugs. You cannot ask for an exception to the copay amount we require you to pay for the drug.
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our **Drug List** (for more information, refer to Chapter 5).
 - The extra rules and restrictions on coverage for certain drugs include:

? If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- 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 (PA).”)
- Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
- Quantity limits. For some drugs, we limit the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can still ask for an exception to the copay amount we require you to pay for the drug.

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

Section F3 Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

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

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, 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 request for an exception, you can ask for a review of our decision by making an appeal. **Section F5** tells how to make an appeal if we say **No**.

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



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section F4 **How to ask for a coverage decision about a Part D drug or reimbursement
for a Part D Drug, including an exception**

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at **1-877-542-9236 (TTY 711)** 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). Include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read **Section B** to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.

At a glance: How to ask for a coverage decision about a Part D drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from the doctor or other prescriber.
 - You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
 - Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.
-
- If you paid for a drug that you think should be covered, read Chapter 7 of this handbook. Chapter 7 tells how to call Member Services or send us the paperwork that asks us to cover the drug.
 - If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”
 - Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

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

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

You can get a fast coverage decision **only if you are asking for a drug you have not yet received.** (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision **only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.**

If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
- We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
- You can file a “fast complaint” and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to **Section J.**

Deadlines for a “fast coverage decision”

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, this means within 24 hours after we get your doctor’s or prescriber’s statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information,** visit **UHCCommunityPlan.com.**

- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

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

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, this means within 72 hours after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a “standard coverage decision” about payment for 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 will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to the pharmacy within 14 calendar days. The pharmacy will refund your money less any copay you owe.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. This letter will also explain how you can appeal our decision.

Section F5 Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us. Include your name, contact information, and information about the claim.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at **1-877-542-9236 (TTY 711)** 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week).

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 65 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

At a glance: How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 65 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
 - You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.
 - Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.
-
- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week).

The legal term for an appeal to the plan about a Part D drug coverage decision is plan **“redetermination.”**

- If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in **Section F4**.

The legal term for “fast appeal” is **“expedited redetermination.”**

Our plan will review your appeal and give you our decision



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- We take another careful look at all of the information about your coverage request. We check to find out if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a “fast appeal”

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

Deadlines for a “standard appeal”

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a “fast appeal.”
- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for:
 - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
 - If we approve a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get your appeal request. The pharmacy will refund your money less any copay you owe.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section F6 Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will automatically send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week).
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the IRE about a Part D drug is “**reconsideration.**”

Deadlines for “fast appeal” at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a “fast appeal.”
- If the IRE agrees to give you a “fast appeal,” it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for “standard appeal” at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
 - If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
 - If the IRE approves a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get the decision. The pharmacy will refund your money less any copay you owe.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called “upholding the decision.” It is also called “turning down your appeal.”

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE with the decision of your Level 2 appeal will tell you the dollar value needed to continue with the appeal process.

Section G Asking us to cover a longer hospital stay

When you are 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.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any 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, you can ask for a longer hospital stay. This section tells you how to ask.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section G1 Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called An Important Message from Medicare about Your Rights. If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). 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 this notice carefully and ask questions if you don't understand. The Important Message 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.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). 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. The call is free.

You can also refer to the notice online at **[cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html)**.

- If you need help, please call Member Services or Medicare at the numbers listed above.

Section G2 Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to find out if your planned discharge date is medically appropriate for you.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **[UHCCommunityPlan.com](https://www.uhccommunityplan.com)**.

In Ohio, the Quality Improvement Organization is called Livanta. To make an appeal to change your discharge date, call Livanta at: **1-888-524-9900**

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. An Important Message from Medicare about Your Rights contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at **1-888-524-9900** and ask for a “fast review.”

Call before you leave the hospital and before your planned discharge date.

-
- If you do not call to appeal, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at **1-877-542-9236** (TTY **711**) 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). You can also call the MyCare Ohio Ombudsman at **1-800-282-1206** (TTY Ohio Relay Service: **1-800-750-0750**).

What is a Quality Improvement Organization?

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

Ask for a “fast review”

You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term for “fast review” is **“immediate review.”**



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

The legal term for this written explanation is called the “Detailed Notice of Discharge.”

You can get a sample by calling Member Services at **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). 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. Or you can refer to a sample notice online at [cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html)

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit [UHCCommunityPlan.com](https://www.UHCCommunityPlan.com).

Section G3 Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Ohio, the Quality Improvement Organization is called Livanta. You can reach Livanta at: **1-888-524-9900**.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at **1-888-524-9900** and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section H What to do if you think your Medicare home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only when they are covered by Medicare:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
 - With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
 - When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

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

Section H1 We will tell you in advance when your coverage will be ending

You will get a notice 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 we will stop covering your care and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying the cost for your care.

Section H2 Level 1 Appeal to continue your care

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

Before you start your appeal, understand what you need to do and what the deadlines are.

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. **Section J** tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at **1-877-542-9236** (TTY **711**) 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). Or call the MyCare Ohio Ombudsman at **1-800-282-1206** (TTY Ohio Relay Service: **1-800-750-0750**).

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Ohio, the Quality Improvement Organization is called Livanta. You can reach Livanta at: **1-888-524-9900**. Information about appealing to the Quality Improvement Organization is also in the Notice of Medicare Non-Coverage. This is the notice you got when you were told we would stop covering your care.

What is a Quality Improvement Organization?

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

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at 1-888-524-9900 and ask a “fast-track appeal.”

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What should you ask for?

Ask them for a “fast-track appeal.” This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

The legal term for the written notice is “**Notice of Medicare Non-Coverage.**” To get a sample copy, call Member Services at **1-877-542-9236** (TTY **711**) 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or refer to a copy online at cms.gov/medicare/medicare-general-information/bni

What happens during the Quality Improvement Organization’s review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
 - When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
 - The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
 - **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.
-

The legal term for the letter explaining why your services should end is “**Detailed Explanation of Non-Coverage.**”

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

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

Section H3 Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit UHCCommunityPlan.com.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

In Ohio, the Quality Improvement Organization is called Livanta. You can reach Livanta at: **1-888-524-9900**. Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at 1-888-524-9900 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section I Taking your appeal beyond Level 2

Section I1 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 your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can contact the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the MyCare Ohio Ombudsman. The phone number is **1-800-282-1206** (TTY Ohio Relay Service: **1-800-750-0750**).

Section I2 Next steps for Medicaid services and items

If you had a State Hearing for services covered by Medicaid and your State Hearing decision was overruled (not in your favor), you also have the right to additional appeals. The State Hearing decision notice will explain how to request an Administrative Appeal by submitting your request to the Bureau of State Hearings. The Bureau of State Hearings must get your request within 15 calendar days of the date the hearing decision was issued. If you disagree with the Administrative Appeal decision, you have the right to appeal to the court of common pleas in the county where you live.

If you have any questions or need assistance with State Hearings or Administrative Appeals, you can contact the Bureau of State Hearings at **1-866-635-3748**.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section J How to make a complaint

Section J1 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, receiving a bill, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- UnitedHealthcare Connected® for MyCare Ohio staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Complaints about receiving a bill

- Your doctor or provider sent you a bill.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying the provider for certain medical services so they can refund your money.
- You believe we did not forward your case to the Independent Review Entity on time.

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read **Section J3**.

If you need help making an internal and/or external complaint, you can call the MyCare Ohio Ombudsman at **1-800-282-1206** (TTY Ohio Relay Service: **1-800-750-0750**).

The legal term for a “complaint” is a “**grievance.**”

The legal term for “making a complaint” is “**filing a grievance.**”

Are there different types of complaints?



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Yes. 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 that is not affiliated with our plan. **If you need help making an internal and/or external complaint, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).**

Section J2 Internal complaints

To make an internal complaint, call Member Services at **1-877-542-9236 (TTY 711)** 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week). Complaints related to Part D must be made **within 60 calendar days** after you had the problem you want to complain about. All other complaints can be made at any time after you had the problem you want to complain about.

- 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. You can also use the form to submit the complaint.
- 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. If we do not accept your grievance in whole or in part, our written decision will explain why it was not accepted, and will tell you about options you may have. The address and fax numbers for filing complaints are located in Chapter 2 under “How to contact us when you are making a complaint about your medical care or for Part D prescription drug complaints”.

The legal term for “fast complaint” is **“expedited grievance.”**

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer complaints about access to care within 2 business days. We answer all other complaints within 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236 (TTY 711)**, 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will 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 will respond whether we agree with the complaint or not.

Section J3 External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: **[medicare.gov/MedicareComplaintForm/home.aspx](https://www.medicare.gov/MedicareComplaintForm/home.aspx)**.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**. The call is free.

You can tell Medicaid about your complaint

You can call the Ohio Medicaid Hotline at **1-800-324-8680** or TTY **711**. The call is free. You can also e-mail your complaint to **bmhc@medicaid.ohio.gov**.

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services’ Office for Civil Rights 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 Office for Civil Rights is **1-800-368-1019**. TTY users should call **1-800-537-7697**. You can also visit **ocrportal.hhs.gov/ocr/portal/lobby.jsf**.

You may also contact the local Office for Civil Rights office at:

Office of Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, Illinois 60601

You may also have rights under the Americans with Disability Act. You can contact Member Services at **1-877-542-9236** (TTY **711**) 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day, 7 days a week) or the Ohio Medicaid Consumer Hotline at **1-800-324-8680** (TTY: **711**) for assistance.

You can file a complaint with the Quality Improvement Organization



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **[UHCCommunityPlan.com](https://www.uhccommunityplan.com)**.

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us and to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, refer to Chapter 2.

In Ohio, the Quality Improvement Organization is called Livanta. The phone number for Livanta is **1-888-524-9900**.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

Grievance and appeal form

Member's name: _____ ID#: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone number(s): _____

If you would like to file a grievance about service you received, or appeal a decision that was made about your coverage, complete this form. Please describe your concern in detail. Include names, dates, and places of services. Use the back side, if needed. Sign and date this form. Then mail to the address below.

We will let you know that we received this form, and what to expect next. You can also find more information in your **Member Handbook**.

Signature: _____ Date: _____

Part C and D Grievances and Part C Appeals:

UnitedHealthcare Community Plan
Attn: Complaint and Appeals Department
P.O. Box 6103, MS CA120-0360
Cypress, CA 90630-0023

Expedited Fax: 1-866-373-1081
Standard Fax: 801-994-1082

Part D Appeals:

UnitedHealthcare Community Plan
Attn: Part D Standard Appeals
P.O. Box 6103, MS CA120-0368
Cypress, CA 90630-0023

Part D Appeals Fax: 877-960-8235





UnitedHealthcare Connected® for MyCare Ohio is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

You can get this information for free in other languages. Call **1-877-542-9236**, TTY **711**. The call is free.

Usted puede obtener esta información de forma gratuita en otros idiomas. Llame al **1-877-542-9236**, TTY **711**. La llamada es gratuita.

Chapter 10

Changing or ending your membership in our MyCare Ohio Plan

Introduction

This chapter tells about ways you can change or end your membership in our plan. You can change your membership in our plan by choosing to get your Medicare services separately (you will stay in our plan for your Medicaid services). You can end your membership in our plan by choosing a different MyCare Ohio plan. If you leave our plan, you will still be in the Medicare and Ohio Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the **Member Handbook**.

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If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section A MyCare Ohio

You can end your membership in UnitedHealthcare Connected® for MyCare Ohio at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

If you change your membership in our plan by choosing to get Medicare services separately:

- You will keep getting Medicare services through our plan until the last day of the month that you make a request.
- Your new Medicare coverage will begin the first day of the next month. For example, if you make a request on January 18th to not have Medicare through our plan, your new Medicare coverage will begin February 1st.

If you end your membership in our plan by choosing a different MyCare Ohio plan:

- If you ask to switch to a different MyCare Ohio plan before the last five days of a month, your membership will end on the last day of that same month. Your new coverage in the different MyCare Ohio plan will begin the first day of the next month. For example, if you make a request on January 18th, your coverage in the new plan will begin February 1st.
- If you ask to switch to a different MyCare Ohio plan on one of the last five days of a month, your membership will end on the last day of the following month. Your new coverage in the different MyCare Ohio plan will begin the first day of the month after that. For example, if we get your request on January 30th, your coverage in the new plan will begin March 1st.

You can get more information about when you can change or end your membership by calling:

- The Ohio Consumer Medicaid Hotline at **1-800-324-8680**, Monday–Friday from 7 a.m.–8 p.m. and Saturday from 8 a.m.–5 p.m. TTY users should call the Ohio Relay Service at **7-1-1**.
- 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**.

NOTE: If you are in a drug management program, you may not be able to change plans. Refer to Chapter 5 for information about drug management programs.

Section B How to change or end your membership in our plan

If you decide to change or end your membership:

- Call the Ohio Medicaid Consumer Hotline at **1-800-324-8680**, Monday–Friday from 7 a.m.–8 p.m. and Saturday from 8 a.m.–5 p.m. TTY users should call the Ohio Relay Service at **7-1-1**; or



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- Call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing, or speaking) should call **1-877-486-2048**. When you call **1-800-MEDICARE**, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in **Section D1**.

Refer to Section A above for information on when your request to change or end your membership will take effect.

Section C How to join a different MyCare Ohio plan

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different MyCare Ohio plan.

To enroll in a different MyCare Ohio plan:

- Call the Ohio Medicaid Consumer Hotline at **1-800-324-8680**, Monday–Friday from 7 a.m.–8 p.m. and Saturday from 8 a.m.–5 p.m. TTY users should call the Ohio Relay Service at **7-1-1**.

Your coverage with UnitedHealthcare Connected® for MyCare Ohio will end on the last day of the month that we get your request.

Section D How to get Medicare and Medicaid services

If you do not want to enroll in a different MyCare Ohio plan, you will return to getting your Medicare and Medicaid services separately. Your Medicaid services will still be provided by UnitedHealthcare Connected® for MyCare Ohio.

Section D1 Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically stop getting Medicare services from our plan.



If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

<p>1. You can change to:</p> <p>A Medicare health plan, such as a Medicare Advantage plan, which would include Medicare prescription drug coverage</p>	<p>Here is what to do:</p> <ul style="list-style-type: none"> • 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. <p>If you need help or more information:</p> <ul style="list-style-type: none"> • Call the Ohio Medicaid Consumer Hotline at 1-800-324-8680, Monday–Friday from 7 a.m.–8 p.m. and Saturday from 8 a.m.–5 p.m. TTY users should call the Ohio Relay Service at 7-1-1. <p>You will automatically stop getting Medicare services through UnitedHealthcare Connected® for MyCare Ohio when your new plan’s coverage begins.</p>
<p>2. You can change to:</p> <p>Original Medicare with a separate Medicare prescription drug plan</p>	<p>Here is what to do:</p> <ul style="list-style-type: none"> • 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. You can select a Part D plan at this time. <p>If you need help or more information:</p> <ul style="list-style-type: none"> • Call the Ohio Medicaid Consumer Hotline at 1-800-324-8680, Monday–Friday from 7 a.m.–8 p.m. and Saturday from 8 a.m.–5 p.m. TTY users should call the Ohio Relay Service at 7-1-1. <p>You will automatically stop getting Medicare services through UnitedHealthcare Connected® for MyCare Ohio when your Original Medicare and prescription drug plan coverage begins.</p>

? If you have questions or need to speak with your care manager, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

<p>3. You can change to:</p> <p>Original Medicare without a separate Medicare prescription drug plan</p> <p>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.</p> <p>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 your Ohio Senior Health Insurance Information Program (OSHIIP) at 1-800-686-1578.</p>	<p>Here is what to do:</p> <ul style="list-style-type: none">• 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. <p>If you need help or more information:</p> <ul style="list-style-type: none">• Call the Ohio Medicaid Consumer Hotline at 1-800-324-8680, Monday–Friday from 7 a.m.–8 p.m. and Saturday from 8 a.m.–5 p.m. TTY users should call the Ohio Relay Service at 7-1-1. <p>You will automatically stop getting Medicare services through UnitedHealthcare Connected® for MyCare Ohio when your Original Medicare coverage begins.</p>
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Section D2 How to get your Medicaid services

You must get your Medicaid benefits from a MyCare Ohio plan. Therefore, even if you do not want to get your Medicare benefits through a MyCare Ohio plan, you must still get your Medicaid benefits from UnitedHealthcare Connected® for MyCare Ohio or another MyCare Ohio managed care plan.

If you do not enroll in a different MyCare Ohio plan, you will remain in our plan to get your Medicaid services.

Your Medicaid services include most long-term services and supports and behavioral health care.

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Once you stop getting Medicare services through our plan, you will get a new member ID card and a new **Member Handbook** for your Medicaid services.

If you want to switch to a different MyCare Ohio plan to get your Medicaid benefits, call the Ohio Medicaid Consumer Hotline at **1-800-324-8680**, Monday–Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at **711**.

Section E Keep getting your medical items, services and drugs through our plan until your membership ends

If you change or end your enrollment with UnitedHealthcare Connected® for MyCare Ohio, it will take time before your new coverage begins. During this time, you will keep getting your Medicare and Medicaid services through our plan.

- 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 changes or ends, your hospital stay will be covered by our plan until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

Section F Other situations when your membership ends

These are the cases when Medicare and Medicaid must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage. Medicare services will end on the last day of the month that your Medicare Part A or Medicare Part B ends.
- If you no longer qualify for Medicaid or no longer meet MyCare Ohio eligibility requirements. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months or you establish primary residence outside of Ohio.
 - 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.

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

- 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 ask Medicare and Medicaid to end your enrollment with our plan for the following reasons:

- If you intentionally give incorrect information when you are enrolling and that information affects your eligibility.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members.
- If you let someone else use your Member ID Card to get medical care.
 - If your membership ends for this reason, Medicare and/or Medicaid may have your case investigated by the Inspector General. Criminal and/or civil prosecution is also possible.

Section G **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.

You should also call the Ohio Medicaid Consumer Hotline at **1-800-324-8680**, Monday–Friday from 7 a.m.–8 p.m. and Saturday from 8 a.m.–5 p.m. TTY users should call the Ohio Relay Service at 7-1-1.

Section H **Your right to make a complaint if we ask Medicare and Medicaid to end your membership in our plan**

If we ask Medicare and Medicaid to end your membership in our plan, we must tell you our reasons in writing. We must also explain how you can file a grievance or make a complaint about our request to end your membership. You can also refer to Chapter 9 for information about how to make a complaint.

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCCommunityPlan.com**.

Section I How to get more information about ending your plan membership

If you have questions or would like more information on when Medicare and Medicaid can end your membership, you can call Member Services at **1-877-542-9236** (TTY **711**), 8 a.m.–8 p.m. local time, Monday–Friday (voice mail available 24 hours a day, 7 days a week).

? **If you have questions or need to speak with your care manager**, please call UnitedHealthcare Connected® for MyCare Ohio at **1-877-542-9236** (TTY 711), 8 a.m.–8 p.m. local time, Monday–Friday (voicemail available 24 hours a day/7 days a week). **For more information**, visit **UHCommunityPlan.com**.

Chapter 11

Definitions of important words

Introduction

This chapter includes key terms used throughout the **Member Handbook** with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living (Chapter 2, Section A): the things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Ambulatory surgical center (Chapter 4, Section D): a facility that provides outpatient surgical services to patients who do not need hospital care and who are not expected to need more than 24 hours of care in the facility.

Appeal (Chapter 1, Section I): a formal way for you to challenge our decision if you think we made a mistake. You can ask us to change or reverse our decision by filing an appeal. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including telling you how to make an appeal.

Behavioral health services (Chapter 3, Section F): treatments for mental health and substance use.

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.

Biosimilar: A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without getting a new prescription. (See "Interchangeable Biosimilar").

Brand-name drug (Chapter 6, Section D): a prescription drug that is made and sold by the company that first made the drug. Brand-name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care manager (Chapter 1, Section C): one main person who works with you, UnitedHealthcare Connected® for MyCare Ohio, and your care providers to make sure that you get the care you need.

Care plan (Chapter 1, Section C): a plan that describes which health services you will get and how you will get them. (Also known as a Personal Care Plan.)



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Care team (Chapter 1, Section C): a team that may include doctors, nurses, counselors, other health professionals, and others who you choose who help you get the care you need. Your care team will also help you make an individualized care plan.

Catastrophic-coverage stage (Chapter 6, Section C): the part of the Part D drug benefit where the plan pays all of the costs of your drugs until the end of the year. You begin this stage when you have reached the \$2,000 limit for your prescription drugs.

Centers for Medicare & Medicaid Services (CMS) (Chapter 2, Section F): the federal agency in charge of Medicare. Chapter 2 explains how to contact CMS.

Community Based Adult Services (CBAS) (Chapter 4, Section D): outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services to eligible Enrollees who meet applicable eligibility criteria.

Complaint or Grievance (Chapter 2, Section A): a written or spoken statement saying that you have a concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies.

Comprehensive outpatient rehabilitation facility (CORF) (Chapter 4, Section D): a facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Copay (Chapter 5, Section A): A fixed amount you pay each time you get a service or supply. For example, you might pay \$1 or \$4.15 for a prescription drug. UnitedHealthcare Connected® for MyCare Ohio only charges copays for prescription drugs and some other things you get at the pharmacy.

Cost-sharing (Chapter 6, Section A): amounts you have to pay when you get drugs. Cost-sharing includes copays.

Cost-sharing tier (Chapter 6, Section B): a group of drugs with the same copay. Every drug on the **Drug List** is in one of three cost-sharing tiers. In general, the higher the cost-sharing tier, the more you must pay for the drug.

Coverage decision (Chapter 2, Section A): a decision about which benefits we cover. This includes decisions about covered drugs and services, or the amount that we will pay for your health services. Chapter 9 explains how to ask us for a coverage decision.

Covered drugs (Chapter 1, Section J): the term we use to mean all of the drugs that our plan covers.



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Covered services (Chapter 2, Section A): 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 that our plan covers.

Daily cost-sharing rate (Chapter 6, Section F): a rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply. Here is an example: If your copay for a one-month supply of a drug is \$30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is \$1 per day. This means you pay \$1 for each day's supply when you fill your prescription.

Disenrollment (Chapter 10, Section A): the process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice, for example if you are no longer eligible for Medicaid).

Durable medical equipment (DME) (Chapter 4, Section D): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency (Chapter 3, Section H): a medical condition that a prudent layperson with an average knowledge of health and medicine, would expect is so serious that if it does not get immediate medical attention it could result in death, serious dysfunction of a body organ or part, or harm to the function of a body part, or, with respect to a pregnant woman, place her or her unborn child's physical or mental health in serious jeopardy. Medical symptoms of an emergency include severe pain, difficulty breathing, or uncontrolled bleeding. Mental health symptoms of an emergency or non-life threatening emergency include: threat of suicide, homicide or self-injury, mania or psychosis that needs immediate medical attention.

Emergency care (Chapter 3, Section H): covered services needed to treat a medical emergency, given by a provider trained to give emergency services.

Enrollment (Chapter 1, Section E): the process of becoming a member in our plan.

Exception (Chapter 9, F2): permission to get coverage for a drug that is not normally covered by our plan or to use the drug without certain rules and limitations.

Extra Help (Chapter 6, Introduction): a Medicare program that helps people with limited incomes and resources to pay for Medicare Part D prescription drugs. Extra help is also called the "Low-Income Subsidy," or "LIS."

Generic drug (Chapter 6, Section D): a prescription drug that is 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.



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Grievance: Refer to “Complaint or Grievance.”

Health plan (Chapter 1, Section F): an organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care managers to help you manage all your providers and services. They all work together to make sure you get the care you need.

Health assessment (Chapter 1, Section F): a review of a patient’s medical, mental health, and substance use history and current conditions. It is used to determine the patient’s health and how it might change in the future.

Home health aide (Chapter 4, Section D): a person who provides services that do not need the skills of a licensed nurse or therapist, like help with personal care (for example, bathing, using the toilet, dressing, or doing the exercises that a provider orders). Home health aides do not have a nursing license or provide therapy.

Hospice (Chapter 4, Section D): A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. 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. UnitedHealthcare Connected® for MyCare Ohio must give you a list of hospice providers in your geographic area.

Improper/inappropriate billing (Chapter 7, Section A): A situation when a provider (such as a doctor or hospital) bills you more than the plan’s cost sharing amount for services. Show your UnitedHealthcare Connected® for MyCare Ohio Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand. Because UnitedHealthcare Connected® for MyCare Ohio pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

Independent Living and Long-term Services and Supports (IL-LTSS) Coordinator (Chapter 2, Section A): a person who works with you and your care team to make sure you get the services and supports you need for independent living. (Also known as a Long Term Supports (LTS) Coordinator.)

Independent Review Entity (IRE) (Chapter 9, E3): the independent organization hired by Medicare to review External (Level 2) Appeals if we don’t decide fully in favor of your Internal Appeal.

Initial-coverage stage (Chapter 6, Section C): the stage before your total Part D drug expenses reach \$2,000. This includes the amounts you have paid, the amounts our plan has paid for you, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays part of the costs of your drugs, and you pay your share.



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Inpatient (Chapter 4, Section D): a term used when you have been officially admitted to the hospital for skilled medical services. If you were not officially admitted, you might still be considered outpatient instead of inpatient, even if you stay in the hospital overnight.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Level 1 Appeal (Chapter 9, E3): a request by a member to a plan to review an Adverse Action (also called an Internal Appeal).

Level 2 Appeal (Chapter 9, E5): an appeal sent to an independent organization not connected to the plan to review the plan's decision on a Level 1 Appeal (the first stage in an External Appeal for a Medicare service).

List of Covered Drugs (Drug List) (Chapter 1, Section J): a list of prescription drugs covered by UnitedHealthcare Connected® for MyCare Ohio. 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) (Chapter 2, Section A): long-term services and supports are services that 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 home or hospital.

Low-income subsidy (LIS): Refer to "Extra Help"

Medicaid (or Medical Assistance) (Chapter 1, Section B): a program run by the federal and state governments that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Medicaid programs change from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. Refer to Chapter 2 or information about how to contact Medicaid.

Medically necessary (Chapter 3, Section B): means health care services, supplies, or drugs needed for the prevention, diagnosis, or treatment of your sickness, injury or illness that are all of the following as determined by us or our designee, within our sole discretion:

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



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

- Most appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, or illness.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Meet, but do not exceed your medical need, are at least as beneficial as an existing and available medically appropriate alternative, and are furnished in the most cost-effective manner that may be provided safely and effectively.

Medicare (Chapter 1, Section B): the federal health insurance program for certain people: those who are 65 years of age or older, those under age 65 with certain disabilities, and those with end-stage renal disease (generally, this means 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 Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans”, that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Assignment: In Original Medicare, a doctor or supplier "accepts assignment" when they agree to accept the Medicare-approved amount as full payment for covered services.

Medicare-covered services (Chapter 1, Section C): services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee (Chapter 1, Section C): a person who qualifies for both Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dual-eligible beneficiary.”

Medicare Part A (Chapter 1, Section E): the Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B (Chapter 1, Section E): the Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like 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 (Chapter 1, Section E): the Medicare program that lets private health insurance companies provide Medicare benefits through a health plan called a Medicare Advantage Plan.



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Medicare Part D (Chapter 1, Section E): the Medicare prescription drug benefit program. (We call this program “Part D” for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. UnitedHealthcare Connected® for MyCare Ohio includes Medicare Part D.

Medicare Part D drugs (Chapter 5, Section B): drugs that can be covered under Medicare Part D. (Refer to the **Drug List** for covered drugs.) Congress specifically excluded certain categories of drugs from coverage as Part D drugs, but Medicaid may cover some of these drugs.

Member (member of our plan, or plan member) (Chapter 1, Section E): a person with Medicare and Medicaid who qualifies to get covered services, has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and Medicaid.

Member Handbook and Disclosure Information (Introduction): this document and certain others: your enrollment form, and any other attachments, riders, or other optional-coverage-selected documents, which explain your coverage, our responsibilities, and your rights and responsibilities as a member of our plan.

Member Services (Chapter 2, Section A): a department within our plan whose job it is to answer your questions about your membership, benefits, grievances, and appeals. Refer to Chapter 2 for information about how to contact Member Services.

Network pharmacy (Chapter 1, Section J): a pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider (Chapter 1, Section F): “provider” is the general term that we use for doctors, nurses, and others who give you health care 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 the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

Nursing home or facility (Introduction): a place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ohio Department of Medicaid (ODM) (Chapter 1, Section A): The State department in Ohio that administers the Medicaid Program, generally referred to as “the State” in this handbook.

Ombudsman (Chapter 2, Section H): a person or organization in your state that helps you if you are having problems with our plan. The ombudsman’s services are free.



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Organization determination (Chapter 2, Section A): a decision by a plan, or one of its providers, about whether services are covered, or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and 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.
- Covered drugs that need our plan’s prior authorization (PA) are marked in the **Drug List**.

Out-of-network pharmacy (Chapter 1, Section J): a pharmacy that has not agreed to work with our plan to provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan, unless certain conditions are met.

Out-of-network provider or Out-of-network facility (Chapter 3, Section D): a provider or facility that is not employed, owned, or operated by our plan and has not agreed to work with us to provide covered services to members of our plan. Chapter 3 explains out-of-network providers or facilities.

Out-of-pocket costs (Chapter 5, Section A): the cost-sharing requirement for members to pay for part of the services or drugs they get. Refer to the definition for “cost-sharing” above.

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.”

Over-the-counter (OTC) Drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a health care professional.

Personal health information (also called Protected Health Information) (PHI) (Chapter 1, Section K): information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to UnitedHealthcare Connected® for MyCare Ohio’s Notice of Privacy Practices for more information about how UnitedHealthcare Connected® for MyCare Ohio protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.



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Primary care provider (PCP) (Chapter 3, Section D): your primary care provider is the doctor or other provider that you see first for most health problems. They make sure you get the care you need to stay healthy. They will work with your care team. They also may talk with other doctors and health care providers about your care and may refer you to them. Refer to Chapter 3 for information about getting care from primary care providers.

Prior authorization (PA) (Chapter 3, Section B): approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets PA from our plan. Covered services that need PA are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if you get PA from us. Covered drugs that need PA are marked in the **Drug List**.

Program for All-Inclusive Care for the Elderly (PACE) Plans (Chapter 1, Section E): A program that covers Medicare and Medicaid benefits together for people age 55 and older who need a higher level of care to live at home.

Prosthetics and Orthotics (Chapter 4, Section D): These are medical devices ordered by your doctor or other health care provider. Covered items 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.

Quality improvement organization (QIO) (Chapter 2, Section E): a group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check on and improve the care given to patients. Refer to Chapter 2 for information about how to contact the QIO for your state.

Quantity limits (Chapter 5, Section C): a limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

Real time benefit tool (Chapter 5, Section B): 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.

Rehabilitation services Chapter 4, Section D): treatment you get to help you recover from an illness, accident, or major operation, including physical therapy, speech and language therapy, and occupational therapy. Refer to Chapter 4 to learn more about rehabilitation services.

Service area (Chapter 1, Section D): a specific area covered by a health plan (some health plans accept members only if they live in a certain area). 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. The plan may disenroll you if you move out of the plan's service area.



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Skilled nursing facility (SNF) (Chapter 4, Section D): a nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitation services and other related health services.

Skilled nursing facility (SNF) care (Chapter 4, Section D): skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of SNF care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist (Chapter 3, Section D): a doctor who provides health care for a specific disease or part of the body.

State Hearing (Chapter 9, E4): If your doctor or other provider asks for a Medicaid service that we will not approve, or we will not continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you requested.

Step therapy (Chapter 5, Section C): a coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Subrogation (Chapter 8, Section E): a process of substituting one creditor for another, which applies if you have a legal right to payment from an individual or organization because another party was responsible for your illness or injury. We may use this subrogation right, with or without your consent, to recover from the responsible party or that party's insurer the cost of services provided or expenses incurred by us that are related to your illness or injury.

Supplemental Security Income (SSI) (Chapter 1, Section B): a monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care (Chapter 3, Section H): 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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UnitedHealthcare Connected® for MyCare Ohio Member Services:



Call 1-877-542-9236

Calls to this number are free.

8 a.m.–8 p.m. local time, Monday–Friday.

(Voicemail is available 24 hours a day, 7 days a week.)

Member Services also has free language interpreter services available for non-English speakers.

TTY 711

Calls to this number are free.

8 a.m.–8 p.m. local time, Monday–Friday.

(Voicemail is available 24 hours a day, 7 days a week.)



**Write: UnitedHealthcare Community Plan of Ohio, Inc.
5900 Parkwood Place
Dublin, OH 43016**



**UHCCommunityPlan.com
myuhc.com/CommunityPlan**